AN EVALUATION OF SELECTED COMMUNITY-BASED HEALTH PROGRAMS AND INSTITUTIONS IN THE PHILIPPINES

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FOREWORD

When the health team of the Rural Missionaries of the Philippines launched the Paramedic Training Program, as the precursor of Community-Based Health Programs was called then, they had a vision of communities that are self-reliant, self-sustained and self-propelled, able to respond and meet the health needs of its people.

The vision had to be concretized painstakingly through hard work with the people who were themselves the beneficiaries and who, the Health Team believed, would give life to the vision. It was tedious work to translate our western oriented academic knowledge and skills and teach farmers and workers who, for most, have attended only primary school, if any. Much more so, to try to discover what would click with the people and help them make the program of their own. For the Health Team did believe that only through the people's acceptance of the program and making it their own through their full support and participation would the program survive and grow.

Ever since the three pilot programs were initiated to develop a health program employing methods and approaches that veered away from the traditional dole-out, clinic and doctor-centered, western, curative medicine, some form of evaluation based on experience has become a regular feature of every CBHP. It is precisely these regular evaluations and what came out of them that provided the concrete basis for improvement and overall change in methods and approaches needed to fit the changing local situations. Regular evaluation processes have become part of the life of the CBHP and a source of well-grounded pointers for the staff who eventually had to assume managerial responsibilities in the program.

The publication of the Impact Study Evaluation findings is something very special. It focuses on two essential subjects vis-a-vis CBHP: the communities and their health problems and the realities with which the program had to contend in the process of implementation. The thorough and in-depth study of CBHP scrutinizes every angle at every phase of the program on the particular subjects. The work gives one the chance to have an overview of the CBHP's strengths and weaknesses, and at the same time challenges practitioners to give more in order to achieve more for the sake of the people it serves. The study is most appropriate at this time of many changes and challenges not only in the Philippines but in the rest of the world.

The thoroughness and depth with which the study has been done, the clarity of its analysis and the candid recommendations merits the gratitude of every health worker who is sincerely concerned with the health of the majority of or people, whether they serve in CBHPs or in other forms of service.

The study itself is making a significant contribution towards a wholistic view of health with its socio-political and economic relatedness. Such a view, if well understood and sincerely espoused, will eventually make a significant contribution towards a relevant community health service delivery system not only in the Philippines but even for other developing counties in Asia and throughout the world.

Sr. Xavier de Marie Bual, S.P.C.
Chairperson, Community-Based Health Services
Coordinator, Rural Missionaries Community-Based
Health Development Program - Mindanao

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To all the above people and to the countless other Program people whose names are not enumerated here but who nevertheless contributed towards finally making this study a reality, our "MARAMING, MARAMING SALAMAT."

Dr. Magdalena Barcelon
for the NCC of the
CBHP Evaluation

INTRODUCTION

by

Delle Tiongson - Brouwers

INTRODUCTION

CBHP IN BRIEF RETROSPECT

The 1970s :Advent and Active Promotions of CBHP

In the Philippines, the Community-Based approach to the delivery of Primary Health Care Services began in the 70's. The country was experiencing rapid social, economic, cultural and political deterioration. With widespread repression as the order of the day, even development goals for the majority of people became quite difficult to pursue. Development workers had to face the threat of arrest, detention or salvaging because the regime considered mingling with and organizing the grassroots as a subversive activity.

Concerned Church people in the Health Apostolate initiated consultations with grassroots people in the regions. With them, the concept of CBHP was crystallized. CBHP implies an emphasis on preventive not only curative health care, on the use of natural therapies rather than chemical drugs and most of all on the empowerment of the people in handling their health problems. By 1975, it was launched as a diocesan programme in three dioceses, one each in the three main islands of the country. Named as pioneer areas for CBHP were Isabela in Northern Luzon, Leyte in the Visayas and Iligan City in Mindanao.

To this call for the promotion and involvement in community-based programmes, the Rural Missionaries of the Philippines was the first among church organizations to give an organized response on the national level. They pioneered the CBHP programme and sought the support of bishops and other Church institutions for its promotion. CBHP registered positive response and results in communities and amongst organizations and institutions in their search for relevant approaches to health in society. 1976 saw the first of what would become a series of regular annual national evaluations of all organizations and institutions involved in CBHP. It was during the annual evaluations of 1976, 1977, and 1978 that the assembly was able to come out with guidelines and "How To" manuals most especially in the field of curriculum development for the training of Community Health Workers (CHWs) and in incorporating the principles and methods of Community Organizing (CO) in Health. The growth in experience facilitated considerably the production of these manuals. It was also within 1978 when CBHP was able to offer some clear and concrete direction aimed at increasing the number of health professionals who subscribe to CBHP as an effective approach to Primary Health Care delivery service.

The late '70s also saw the establishment of another national programme called Alay Kapwa Kilusang Pangkalusugan (AKAP), which focused on the TB control programme, in coordination with existing CBHP programmes.

Through their first half decade of operations, the different CBH programmes and institutions carried out self-evaluations independent of each other and using individual schemes and frameworks.

The 1980s : Efforts Towards Organizational Systematization

Although many health organizations have realized the need for a common framework for evaluation and comprehensive assessment of the community-based approach to health, these attempts to standardize never materialized for various reasons. Neither was there the opportunity to analyze the impact of the programme on its intended beneficiaries.

The Council for Primary Health Care (CPHC) was established in the 80's in order to coordinate all CBHPs. But CPHC met considerable problems and ended up implementing projects in some areas.

While the presence of some identified weaknesses in the implementation of CBHPs did not dampen individual programme's initiatives at improving its methodologies, there was an unspoken desire to standardize methodologies and systematically learn from each other's experiences.

It was this same moving spirit that prompted MISEREOR in 1984 to sponsor a seminar-workshop on Participatory Evaluation of CBHPs. The purpose of the seminar-workshop was to design an effective guideline for evaluation which encourages optimum participation of all the people involved at all levels of programme implementation. In the mind of the various programme repre- sentatives, a participatory type of evaluation would result in a more people-based/centered assessment of programme achievements.

THE CBHP IMPACT STUDY

Beginnings

Discussions and consultations on the need for a standardized framework for evaluation were done by the Rural Missionaries, CPHC and CBHS-Mindanao in 1987. Apart from a common evaluation framework, the need to look into the common problem areas in programme monitoring and administration as well as staff development surfaced. Having considerably contributed financially to the promotion of CBHPs, MISEREOR reiterated its intention of supporting an impact evaluation of CBHPs by an independent group. MISEREOR proposed Sr. Leonor Barrion, M.D., OSB, Dr. Jaime Galvez-Tan and Dr. Manuel Dayrit to compose the team of evaluators. Initial contact with

these three doctors yielded a negative response. Although each one expressed interest in the evaluation, no one could work full-time on it; however, all three agreed to be consultants to the evaluation study.

While RM, CPHC, and CBHS-Mindanao were convinced about the importance of an impact study, the problem arose as to who will provide the direction and coordination of the activity.

Ongoing consultations among the three institutions gave rise to the recommendation that a staff each of NASSA, RMS and MASAI compose the evaluation team with the three doctors acting as consultants. These three organizations were chosen on the basis of their experience in project evaluation and their knowledge about the evolution of CBHP in the country.

When it became certain that a comprehensive study of CBHPs would be undertaken, CEBEMO, another development agency based in Western Europe, expressed interest in supporting the Study together with MISEREOR. Like MISEREOR, CEBEMO has invested considerably in CBHPs in the Philippines.

On November 19, 1987 the Council for Primary Health Care (CPHC) requested MASAI to play the lead role in coordinating the CBHP Impact Study.

It was therefore on 15th January 1988 when the evaluators' team (composed of Ms. Aleli Marcelino representing NASSA, Mr. Rene Alfonso representing RMS and Ms. Delle Tiongson-Brouwers representing MASAI) and the representatives of the three institutions to be evaluated (RM, CPHC, CBHS-Mindanao) met and discussed how to proceed with the Impact Evaluation.

OBJECTIVES OF STUDY

The general objectives of the Impact Study were identified during the January 15, 1988 meeting. They were further defined in a subsequent meeting which the medical consultants attended.

It was agreed that the study will have three areas as focus: programme impact on the community, institutional capability, and CHW skills. The objectives as spelled out, were:

A. To determine the impact of CBHP on the community

- -to determine the socio-cultural and health impact of the programme on the health status of the community;
- -to determine the extent of community participation and involvement of the people in the whole process;
- -to determine how CBHP facilitated community self-reliance;
- -to determine the current level of implementation of CBHPs at the communities.

B. To determine the capability of the RMP, CPHC and CBHS- various programmes in implementing CBHP

- to determine the efficiency of service delivery by the service institutions as well as their representatives at the regional and community levels;

- to find out the extent of linkages and coordination between institutions and how these institutions tapped and maximized existing resources (of both GOs and NGOs) in support of CBHP;

C. To determine the type and level of health skills of CHWs.

D. To identify main strengths and weaknesses; failure and success factors in the implementation of the CBHPs

E. To come up with recommendations on which to base the future implementation of CBHP.

Methodology: Towards a more participatory scheme of evaluation

With the above objective in mind, the corresponding methodology had to be identified. The National Coordinating Committee (NCC) composed of the consultants, representatives of the RMP, CPHC and CBHS, and Evaluators Team had a series of meetings to decide the appropriate methodology to be able to address the objectives.

To achieve the intention of making the exercise an example of how an evaluation can be participative in its genuine sense, NCC highlighted the involvement in the study not only of the CBHP beneficiaries but also representatives of the three health- related institutions which will be assessed.

ORGANIZATION OF THE REPORT

The report has three main sections. Each section addresses a basic area of concern for CBHP. These sections are: Household Survey (to determine impact), Case Studies (to gauge institutional capability) and CHW Skills, Knowledge and Attitude Test (to assess competence). Though interrelated with each other every section is a full study in itself.

MAIN COMPONENTS

The Community Impact was determined by the Household Survey and interviews in the sample barrios/barangays chosen randomly from the communities served by the three institutions. These barrios/barangays should have CHWs who had completed the basic CHW training prior to January 1986. The rationale for this cut-off date is that the programme should have been in place for at least two years in order to gauge its impact. From a total of 634 barangays (590 in Mindanao, 29 in Luzon and 15 in the Visayas), a total of 30 barangays were chosen as samples. From the list of CHW clients in the barangay, 34 households were randomly chosen as interviewees.

To be able to address the question regarding the capability of RMP, CPHC, CBHS in programme implementation and service delivery, a Case Study for each institution was undertaken. Comprehensive interviews of at least the key personnel of each institution plus review of all their important documents became the bases for the findings and analysis of the Case Studies.

A third component of the Study was the CHW Skills, Knowledge and Attitude Test whose purpose was to determine the type and level of health skills of the Community Health Workers.

Ninety (90) CHWs coming from the same sample barangays of the Household Survey became the total sample for this test. Three (3) CHWs per barangay was the sampling pattern. To maintain the randomness of the choice, the first three CHWs involved in the households that were interviewed were taken as samples. In cases where there were less than three (3) CHWs in a barangay, the next barangay filled up the difference in the number of samples. (For example, barangay A has only 2 CHWs, the sample for barangay B will be the first four (4) CHWs).

THE STUDY TEAM[1]

After the methodology was defined and the scope of work understood, a review of the needed manpower followed. The group which was to be actively involved in all phases of the Study was formed. This group became the National Coordinating Committee (NCC). The composition of the NCC was as follows:

1. The three medical consultants suggested by MISEREOR

   1.1 Dr. Manuel Dayrit

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1 Please refer to Appendix A for the description of the tasks and functions of the different units involved in the study.

1.2 Dr. Jaime Galvez-Tan

1.3 Dr. Ruben Caragay (replaced Sr. Leonor Barrion, OSB, M.D. since the latter was out-of -the-country during the conduct of the Study)

2. Two representatives each from RMP, CPHC and CBHS

2.1 Dr. Magdalena Barcelon &

2.2 Ms. Relinda de la Cruz for RMP

2.3 Mr. Gerardo Andamo &

2.4 Ms. Imelda Garcia for CPHC

2.5 Sr. Susan Bolanio, OND &

2.6 Ms. Del Hernandez for CBHS

3. The Evaluators' Team

3.1 Dr. Virginia Miralao -the Project Director and mainly- in-charge of the Household Survey; the head of the Ramon Magsaysay Awards Foundation Research Group (RMAFRG)

3.2 Dr. Manuel Diaz - represents the RMAFRG at and sits as regular member of NCC; undertook Case Study for CBHS

(NASSA pulled out as regular member of the Team. Dr. Diaz, of the Ramon Magsaysay Awards Foundation Research Group, took NASSA's slot).

3.3 Ms. Asuncion Benitez - conducted Case Study for CPHC, a member of the RMAFRG.

3.4 Ms. Judy Taguiwalo - conducted Case Study for RMP, a member of the RMAFRG.

3.5 Mr. Rene Alfonso - coordinated all activities in rela- tion to Study in Mindanao; also acted as Field Supervisor for interviewers

3.6 Ms. Delle Tiongson-Brouwers - overall Coordinator of Study and Administrator of Study's Funds. She also acted as Field Supervisor for the Visayas.

CONCLUSION

It is the wish of the National Coordinating Committee (NCC) that this Study, despite its limitations, can facilitate the work of those who intend to conduct more in-depth studies on CBHP.

The Study's findings can definitely serve as baseline data for other Health Studies in the future. For those who are new to CBHP, this report will hopefully unfold a whole wealth of information for initiating new CBHPs and improving existing ones.

The NCC further hopes that this Study can contribute to the further promotion of CBHP which is necessary especially within the context of the country's very inadequate health service delivery system and for which only a trickle of the public fund is allotted.

Indeed, much of this lack of adequate health services has to be compensated by people's efforts towards upgrading public service and facilities.

We envision the day when people would manifest the confidence in preventing sickness and maintaining health whilst being able to seek professional medical help whenever necessary without being extremely burdened by its onerous cost.

The Alma Ata Conference envisions "Health For All" by the year 2000. CBHP aims at something higher: **"HEALTH IN THE HANDS OF PEOPLE."**

APPENDIX A

Task and Functions

1.The CPHC Board is the local organization to which NCC is accountable to in relation to the Study

2.The NCC is the body where all major decisions are made relative to the Study

-It ensures that the content of the study is in accordance with agreed principles and guidelines

-It advises the Project Director's Team as to the significant content and methodology of the study.

3.Medical Consultants

-Prepares instrument for CHW skills test;

-administers test on CHWs;

-write findings on CHW skills test;

-advises the Project Director's team on the medical aspect of study;

-sits as regular member of the NCC and attends all its meetings

4.Project Director's Team

-Drafts instrument for Household Interview;

-Finalizes the same together with NCC;

-Prepares Case Study for each programme;

-Trains interviewers;

-Acts as overall Field Supervisor;

-Writes the analysis on household survey.

5.Field Supervisors

-recruits interviewers and translators;

-supervises work of all interviewers on field within his/her assigned region;

-reports to overall coordinator regarding status of field work.

6.Interviewers

-interviews all identified respondents of the study;

-completes the questionnaire and translates answers into English

7.Overall Coordinator

-Takes charge of the overall coordination of the study;

-Communicates and sends needed reports to MISEREOR and CEBEMO regarding project developments and finances of the study;

-Convenes the NCC for meetings;

-Updates the NCC regarding developments in the study, fund receipts and disbursements;

-Administers the fund of the Study;

-Coordinates with the Project Director's team, with the Medical Consultants, with Programme representatives and Field Supervisors regarding their respective responsibilities;

-Ensures that plans are implemented according to schedule

-Takes charge of packaging and reproducing the whole Study report.

A SURVEY OF HEALTH CONDITIONS IN COMMUNITY-BASED HEALTH PROGRAM AREAS

by

Virginia A. Miralao

and

Hector A. Namay

I. A Survey of Health Conditions in Community-Based Health Program Areas

This survey of household health conditions in selected Philippine communities forms part of the evaluation of the pioneering efforts of 3 organizations in community-based health projects in the Philippines. These 3 organizations are the Rural Missionaries of the Philippines (RMP), the Council for Primary Health Care (CPHC), and the Community-Based Health Services (CBHS), whose involvement in primary health care began in 1973, 1980 and 1976, respectively. In addition to the survey, the evaluation has two other components consisting of (1) organizational case studies that document the structure, management and administration of the 3 agencies' programs; and (2) a medical skills test designed to assess the usefulness of the health training provided by the 3 organizations to community health worker-volunteers. This survey component, on the other hand, was meant to provide a basis for assessing the impact of the programs at the level of households and communities.

Because the conduct of a household impact-evaluation was not built into the programs of the RMP, CPHC, and CBHS when they were first established, it was not possible to follow the standard "before-after" study design for the household survey evaluation. Neither was it possible to employ the alternative design of using "control communities" in lieu of "before program" surveys owing to the greater time and resources required for undertaking such alternative "quasi-experimental" designs. Nonetheless, members of the program staff of the three agencies felt that a household survey would be instructive in noting (1) the health conditions and practices of families in communities covered by their programs, and (2) the nature and extent of health services extended by community health workers or CHWs to families.

The Survey Design

In consultation with the respective program staff of the three agencies, a more limited design which entailed the conduct of a single survey in program communities was adopted for the evaluation. To have a basis for assessing the impact of the programs, it was decided that while the survey was to be undertaken only in program-covered communities, attempts will be made to locate and interview (1) households which have been directly served by the community health workers and (2) unserved households or those which have had no contact with the local CHWs. In the survey plan, the "unserved households" would act as the study's "controls" against which to compare the health conditions of, and the health services reaching the "served households."

Following the above design, the research team, together with members of the program and field staff, proceeded to draw the sample communities for the survey. These sample areas were drawn randomly from among the localities reached by the RM, CPHC, and CBHS programs, with some consideration given to the geographical spread or regional distribution of the programs.

Table 1. Total number of program barangays and proposed number of sample barangays and respondent households by region.

	Total no. barangays	Total no. sample bgys.	Total no. of sample households	
			Served	Unserved
Luzon	29 (4.6 %)	5 (16.7 %)	100 (16.7 %)	70 (17.5%)
Visayas	15 (2.4%)	5 (16.7%)	100 (16.7 %)	70 (17.5)
Mindanao	590 (93.0 %)	20 (66.7 %)	400 (66.7 %)	20 (65.0 %)

Because of the highly uneven regional distribution of the programs, it was not feasible to proportionately allocate the sample (or study) communities to the country's major island- or regional groupings which are Luzon, Visayas and Mindanao. The list of program-covered barangays (villages) provided by RMP, CPHC, and CBHS showed Mindanao by far to have the most number of barangays with functioning health programs of two or more years duration, following the sampling criterion that resident CHWs in the project sites must have received their health training before January 1986. Mindanao had 590 such barangays, as against a much fewer 29 for Luzon, and 15 for the Visayas (see Table 1). Consequently, of the predetermined number of sample communities which was set at 30 barangays nationwide, 20 (or 2/3) were drawn from Mindanao while 5 (or 1/6) each were selected from the Luzon and Visayas regions. An equal number of 30 substitute-study communities was also identified in the event field conditions did not warrant easy access to the originally drawn sample barangays.

Based on the survey's resources and time frame, the number of households to be interviewed in the sample communities was set at 1,000 respondent households, 600 of which would be those of "served households." It was agreed that field interviewers would locate the served households from the list of client households maintained by CHWs or identified by them as among the families they have been serving. Likewise, the field interviewers were to validate their selection of unserved households with the CHWs in the sample barangays, even as check questions on CHW and household contact were included in the survey interview schedule.

Finally, since the survey questions that were prepared focused heavily on household health concerns, it was further agreed that the survey respondents consist of mothers under 45 years old. This was to ensure that responses to such questions as pregnancies, child births and child care would pertain to events in the more recent past, or within the period following the establishment of a community-based health program in a given- project site. In addition to the questions on pregnancies, child birth and child care, the survey interview schedule contained questions on several other topics, including the socioeconomic conditions of families, the incidence and nature of illnesses among family members, household diets and nutrition, the household's contact and relations with CHWs and other health personnel, and the household's view and understanding of their community's health and other problems.

Basically following the survey design, our plan was to analyze the survey results by region, and by served and unserved households. The analysis plan would offer a basis for assessing regional differences in the operations of the programs, and for comparing the health-seeking behavior of served and unserved households. Regional analysis of the data, moreover, would be useful to the 3 agencies, in view also of the regional concentrations of their programs. All community-based health program areas in Mindanao were initiated by CBHS, while those in Visayas were established by RMP. Three of the 5 sample communities in Luzon are similarly under the RMP's auspices, while the remaining 2 are with health programs initiated by the CPHC.

Field Operations and Problems

Field survey operations began in late 1988 and continued through the first half of 1989. The rather extended period of data collection owes in part to some logistical/administrative delays, but largely to field difficulties that prompted alterations in the sampling design.

First, intensive government operations that were being undertaken against communist insurgents at the time of the survey prevented access to many of the originally drawn sample barangays. Of the three regions, Mindanao was most affected by militarization, resulting in the substitution of 12 barangays for this reason. In addition, another 4 barangay substitutions were made in the region since some of the originally drawn sample areas did not meet the criterion of having resident CHWs who were trained before January 1986. All the 16 barangay-substitutions in Mindanao, moreover, consisted of 2nd line substitutes as the 1st line substitutes drawn in earlier pre-field sampling operations were similarly threatened by militarization. Although the reasons for the substitutions in the region are understandable, the high substitution rate (16 out of 20 barangays) lessens the representativeness of the survey results for Mindanao. In general, the Mindanao results are now better interpreted as representative of the non-militarized CBHS areas in the region, rather than of the population of CBHS barangays in Mindanao.

Table 2. Reasons and incidence of barangay substitution and final number of respondent households by region.

	Reasons for substitutions	No. of barangay substitutions	No. of eligible respondent HHs	
			Served	Unserved
Luzon	inaccessible	1	84	51
Visayas	critical/militarized	1	105	63
Mindanao	critical/militarized	12	398	254
	CHW trained after Jan. 86	4		
Total		18	587	378

Luzon and Visayas which each had an equivalent number of sample barangays (5) also had one barangay substitution each. The sole barangay substitution in Luzon owed to reasons of inaccessibility, whereas similar to Mindanao, the substitution in the Visayas was due to problems of militarization.

A second set of field problems also affected the original sampling allocation of served and unserved households. These problems had to do with the inclusion of some ineligible respondents (as widows and currently married women but over 45 years old) and the misclassification of households as either "served " or "unserved" by interviewers. In the process of double-checking and cleaning the data, several interviews were dropped because respondents were ineligible, and some others (consisting of between 5% to 11% in the regions) had to be recategorized as "served" and "unserved" using the check questions in the survey questionnaire rather than the classification made by the interviewers. The deficiencies in field interviews resulted in a slightly reduced sample size of 965, and in alterations in the number of "served" and "unserved" households as shown in Table 2. These deficiences owed in part to the high turn-over of resident CHWs which affected the ground validation of served and unserved households, and to the non- familiarity of some of the field interviewers with survey procedures considering that the current study is their first exposure to field survey operations.

As with the barangay substitutions, the recategorization or reclassification of households lessens as well the representativeness of our samples for "served" and "unserved" households. Hence, in the same manner that we cannot readily interpret the Mindanao data as typical of program areas in the region, weaknesses in the classification of households caution us against overly interpreting the differences between "served" and "unserved" households in the survey.

In brief, the changes that were made in sampling selection procedures at the levels of both barangays and households suggest that we cannot emphasize too much comparisons between types

of households and to a certain extent also across regions. Thus, while the survey results presented in the next sections of the report are still given by region and by type of households, findings and trends are described in a general manner, except in cases where regional and/or household differences appear systematic and consistent. Although we may have lost some analytical details owing to changes in the sampling plan, it should be noted that these do not necessarily detract from the generally indicative character of the survey. Neither do these invalidate the basic objectives of the study which were to arrive at descriptions of the health and socioeconomic conditions of households in areas covered by the RMP, CPHC and CBHS community- based health programs, and of the role and nature of services extended by CHWs in program-covered areas.

Presentation and Organization of the Survey Findings

The survey findings, which are discussed in the subsequent sections of the report, have been organized into 4 major parts. On the premise that household health is a function of the economic well-being of families, the adequacy of their diets, and their access to local health care, the first part presents survey results on (a) the socioeconomic conditions of households, (b) household diets and nutrition, and (c) the availability of health facilities in the sample barangays. In presenting these items first, we are assuming that these constitute the more enduring and immediate factors that influence the health status of families and local communities.

The second part presents the survey results bearing on the health conditions of household members. The indicators of "household health" are taken from responses to survey questions on the frequency and nature of illnesses experienced by family members in the recent past; the incidence of mortality among children and adults; and the prevalence of physical disabilities among family members.

The third part seeks to describe the patterns of health- seeking behavior of households, i.e., what they do and whom they consult in times of illnesses. Also discussed in this section are local practices surrounding pregnancies, childbirths and family planning, as well as infant feeding and the care and immunization of children.

The fourth section of the report details the findings on the relationships between CHWs and their client households. Specifically, the items included here are the frequency and nature of interaction between households and CHWs; the usual type of services rendered by CHWs; the support given by households to CHWs and the local community-based health program; and the respondents' perceptions of the health and other needs of their localities.

The report ends with a concluding note that summarizes the study's major findings and their implications for promoting or improving the operations of community-based health programs in the Philippines.

Table 3. Selected background characteristics of served and unserved respondent households by Region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Mean HH size	6.5	6.3	6.2	6.2	6.2	5.7
B. Nature of economic activities						
% in farming	77.4%	82.0%	26.7	11.1%	71.1%	78.4%
% in fishing	1.2%	-	17.1%	11.1%	6.6%	4.5%
% in nonfarm/nonfishing activities	45.2%	34.4%	60.0%	74.6%	37.5%	39.8%
C. Mean annual income from various sources						
Farming	4,695	4,635	5,362	3,460	5,999	6,234
Fishing	2,600	-	9,267	3,351	9,718	18,560
Nonfarm/nonfishing	15,751	15,251	13,442	16,532	18,614	14,244
Other sources	2,452	2,007	1,486	3,656	1,998	2,014
Remittances	3,902	1,237	413	4,089	5,206	325
D. Mean annual income from all sources	13,504	10,675	11,894	14,835	13,340	10,544
E. Percent saying income is ____ than 5 years ago						
very much higher	2.4%	-	-	3.2%	-	-
slightly higher	14.3%	18.0%	36.2%	39.7%	23.0%	25.0%
the same	35.7%	45.9%	32.4%	36.5%	26.3%	29.5%
slightly less	33.3%	31.1%	31.4%	19.0%	42.1%	37.5%
very much less	14.3%	4.9%	-	1.6%	8.6%	8.0%
F. Percent saying income is ____ than other HHs in the community						
very much higher	1.2%	1.6%	1.9%	-	-	-
slightly higher	16.7%	16.4%	22.9%	14.3%	11.2%	8.0%
the same	45.2%	45.9%	47.6%	65.1%	52.0%	53.4%
slightly less	28.6%	29.5%	27.6%	20.6%	27.6%	33.0%
very much less	8.3%	6.6%	-	-	9.2%	5.7%
G. HH lighting facilities						
% using electricity	65.5%	68.9%	34.3%	55.6%	28.9%	35.2%

Table 3 (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
% using kerosene	33.3%	29.5%	65.7%	44.4%	71.1%	62.5%
% using others (e.g., oil)	1.2%	1.6%	-	-	-	2.3%
H. HH water facilities						
% with in-house piped water	4.8%	-	6.7%	11.1%	-	1.1%
% with piped water outside house	8.3%	3.3%	51.4%	68.2%	21.7%	15.9%
% with pumped water	73.8%	80.3%	16.2%	7.9%	46.7%	45.4%
% with open well water source	13.1%	16.4%	25.7%	12.7%	11.8%	14.8%
% with rain as water source	-	-	-	-	10.5%	10.2%
% with spring as water source	-	-	-	-	9.2%	12.5%
I. HH cooking facilities						
% using wood	94.0%	95.1%	93.3%	85.7%	98.7%	100.0%
% using kerosene	2.4%	1.6%	6.7%	6.3%	0.7%	-
% using LPG	3.6%	3.3%	-	7.9%	0.7%	-
J. HH toilet facilities						
% with no toilets	16.7%	8.2%	39.0%	30.2%	10.5%	9.1%
% with open pit toilets	3.6%	13.1%	-	-	5.3%	11.4%
% with closed pit toilets	2.4%	4.9%	1.9%	1.6%	20.4%	17.0%
% with water-sealed toilets	76.2%	73.8%	58.1%	61.9%	63.8%	62.5%
% with flush toilets	1.2%	-	1.0%	6.3%	-	-
K. HH garbage disposal practices						
% burying garbage	-	-	18.1%	22.2%	6.6%	2.3%
% burning garbage	84.5%	90.2%	42.9%	34.9%	55.3%	52.3%
% composting garbage	-	-	5.7%	1.6%	21.7%	21.6%
% dumping garbage	15.5%	9.8%	33.3%	41.3%	16.4%	23.9%

II. The Socioeconomic and Health-Related Backgrounds of Households

Socioeconomic Conditions of Households

The data on the socioeconomic backgrounds of the survey households are summarized in Table 3, which show them to generally exhibit the same characteristics as other Filipino rural households.

Families in the program-covered areas are typically large families, with at least 5 to 6 members, while many others have over 6 members. The families engage in multiple kinds of livelihood activites, combining work in agriculture (farming and fishing) with other lowly paid off-farm occupations. Compared to the Luzon and Mindanao study communities which are more agricultural, Table 3 reveals that those in the Visayas are more urban, since fewer of the households in the latter region engage in farming and fishing. Nonetheless, since the farm and off-farm work available in the program communities are generally unremunerative, the total incomes of families are low and do not differ much across regions. Their average household incomes, which range from around P10,500 to P14,000 per annum, show that the respondent-households live in abject poverty, and come from the ranks of the estimated 60% of the national population whose incomes fell below the official poverty threshold of about P2,000 per month per household in the mid-1980s. Although the data reveal some differences in the household incomes between served and unserved households, these differences are not substantial, and neither are the directions of the differences consistent across regions. To the extent that the sample areas typify those served by the RMP, CPHC and CBHS, the more salient finding from the survey's income data is that the areas reached by the community health programs of the 3 agencies consist of economically depressed localities.

Real economic difficulties in the program areas are also reflected in the respondents' own feelings about their economic state. Compared to 5 years ago, most respondents report no improvements in their incomes even as the cost of food and other basic commodities steadily rose during the period. In fact, close to half of the Luzon and Mindanao respondents report that their household earnings at present are less than what they used to earn 5 years ago. The Visayas respondents are somewhat more optimistic in this regard as a higher 36% to 40% of them feel their incomes have improved over the last 5-year period.

Similarly, when asked to rank their households vis-a-vis other families in the community, most households are not inclined to rate themselves as "richer" than their neighbors. Indeed, a considerable 37% to 39% of the Luzon and Mindanao respondents and 21% to 28% of the Visayas respondents rank themselves as "poorer" than other households in their barangays. On the whole, these subjective feelings on incomes indicate a sense of economic stagnation in the study communities. Respondents do not sense that their families have been upwardly mobile, and neither do they feel that economic progress has taken place in their communities. In terms of housing facilities and amenities, Table 3 shows considerable differences across regions which likely reflect the uneven development of the country's regions. In view of the more advanced infrastructural development of Luzon, respondent-households from the region are more favored in terms of electric power and

Table 4. Related data on household staple food and HH involvement in food production activities by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Percent of HHs who depend on rice/corn for						
7 - 8 mos. of the year	8.3%	-	-	-	-	-
9 mos. of the year	3.6%	1.6%	1.0%	1.6%	-	-
10 mos. of the year	2.4%	-	3.8%	3.2%	-	-
11 mos. of the year	-	-	1.0%	1.6%	0.7%	-
all year round	85.7%	98.4%	94.2%	93.6%	99.3%	100.0%
B. Number of HHs whose staple food consists of rootcrops and/or bananas for 1 to 5 months each year	11	1	8	4	3	-
C. Percent of HHs raising livestock or poultry for consumption	82.1%	90.2%	66.7%	49.2%	75.7%	65.9%
D. Number of chickens raised by HH per year						
none	4.3%	3.6%	28.6%	29.0%	18.3%	20.7%
1 - 5 heads	29.0%	32.7%	41.4%	45.2%	20.0%	25.9%
6 - 10 heads	29.0%	27.3%	20.0%	19.4%	13.9%	13.8%
over 10 heads	37.7%	36.4%	10.0%	6.4%	47.8%	39.7%
E. Number of pigs raised by HH per year						
none	42.0%	41.8%	45.7%	45.2%	40.9%	37.9%
1 - 5 heads	58.0%	58.2%	52.9%	41.9%	48.7%	55.2%
6 - 10 heads	-	-	1.4%	9.7%	2.6%	3.4%
over 10 heads	-	-	-	3.2%	7.8%	3.4%
F. Number of carabaos raised by HH per year						
none	52.2%	49.1%	98.6%	96.8%	78.3%	89.7%
1 head	33.3%	36.4%	-	3.2%	14.8%	5.2%
2 or more heads	14.5%	14.5%	1.4%	-	7.0%	5.2%

Table 4. (Cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
G. Number of other livestock (e.g., ducks) raised by HH per year						
none	62.3%	72.7%	88.6%	90.3%	73.9%	75.9%
1 - 5 heads	30.4%	25.4%	4.3%	6.4%	17.4%	22.4%
6 - 10 heads	2.9%	1.8%	5.7%	-	2.6%	1.7%
over 10 heads	4.3%	-	1.4%	3.2%	6.1%	-
H. Number of HHs raising vegetables and fruits for their consumption	73%	70%	40%	25%	83%	75%
I. Food items commonly bought by HHs (multiple response)						
% buying rice	21.4%	8.2%	84.8%	84.1%	23.7%	21.6%
% buying fish/dried fish	22.6%	18.0%	93.3%	100.0%	91.4%	88.6%
% buying meat	8.3%	6.6%	8.6%	9.5%	22.4%	19.3%
% buying eggs	2.4%	-	3.8%	4.8%	1.3%	1.1%
% buying vegetables	6.0%	1.6%	52.4%	69.8%	19.7%	22.7%
% buying bagoong	47.6%	55.7%	28.6%	20.6%	44.7%	53.4%
% buying coffee, sugar	92.9%	100.0%	12.4%	7.9%	18.4%	25.0%

Table 5. Related data on usual household diets by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Number of kilos of rice consumed by HH per week						
less than 10 kgs.	13.4%	16.9%	16.2%	33.3%	21.2%	26.4%
10 - 19 kgs.	64.6%	62.7%	53.3%	38.1%	49.0%	40.2%
20 - 29 kgs.	13.4%	16.9%	26.7%	27.0%	21.8%	27.6%
30 kgs. or more	8.5%	3.4%	3.8%	1.6%	7.9%	5.7%
Mean	16.7	15.3	19.7	14.2	16.0	15.2
B. Number of times HH eats meat per week						
none	13.4%	3.4%	27.6%	23.8%	13.2%	8.0%
once a week	56.1%	67.8%	58.1%	46.0%	69.1%	81.8%
2 - 3 times per week	28.0%	18.6%	8.6%	19.0%	17.8%	10.2%
4 - 5 times per week	1.2%	6.8%	1.9%	-	-	-
more than 5 times per week	1.2%	3.4%	3.8%	11.1%	-	-
C. Number of times HH eats poultry per week						
none	9.6%	3.3%	61.0%	60.3%	29.8%	5 .2%
once a week	67.5%	77.1%	36.2%	22.2%	56.3%	54.5%
2 - 3 times per week	19.3%	16.0%	-	6.3%	13.2%	8.0%
4 - 5 times per week	2.4%	1.6%	-	-	0.7%	-
more than 5 times per week	1.2%	-	2.8%	11.1%	-	2.3%
D. Number of times HH eats eggs per week						
none	-	1.6%	18.1%	25.4%	22.8%	16.3%
once a week	16.1%	19.7%	27.6%	12.7%	24.8%	32.5%
2 - 3 times per week	42.0%	49.2%	21.0%	17.5%	36.2%	33.7%
4 - 5 times per week	9.9%	8.2%	3.8%	3.2%	5.4%	7.0%
more than 5 times per week	32.1%	21.3%	29.5%	41.3%	10.7%	10.5%
E. Number of times HH eats fresh fish per week						
none	4.9%	3.3%	1.0%	3.2%	1.3%	5.7%
once a week	54.3%	52.4%	1.0%	-	27.8%	26.1%
2 - 3 times per week	28.4%	24.6%	13.3%	1.6%	31.8%	31.8%
4 - 5 times per week	3.7%	1.6%	6.7%	-	13.2%	10.2%
more than 5 times per week	8.6%	18.0%	78.1%	95.2%	25.8%	26.1%

Table 5. (Cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
F. Number of times HH eats dried fish per week						
none	24.1%	31.0%	7.6%	9.6%	2.6%	4.5%
once a week	31.3%	31.0%	14.3%	14.3%	32.4%	22.7%
2 - 3 times per week	30.1%	27.6%	22.9%	27.0%	13.9%	19.3%
4 - 5 times per week	6.0%	5.2%	1.0%	1.6%	10.6%	11.4%
more than 5 times per week	8.4%	5.2%	54.3%	47.6%	40.4%	42.0%
G. Number of times HH eats bagoong per week						
none	12.1%	8.2%	17.1%	20.6%	4.8%	9.2%
once a week	10.8%	11.5%	15.2%	19.0%	27.2%	24.1%
2 - 3 times per week	10.8%	11.5%	21.0%	14.3%	12.9%	13.8%
4 - 5 times per week	7.2%	1.6%	1.0%	-	10.2%	9.2%
more than 5 times per week	59.0%	67.2%	45.7%	46.0%	44.9%	43.7%
H. Number of times HH eats vegetables per week						
none	1.2%	-	-	1.6%	-	-
once a week	13.2%	14.8%	4.8%	3.2%	2.0%	1.1%
2 - 3 times per week	20.5%	14.8%	11.4%	9.5%	6.8%	4.5%
4 - 5 times per week	4.8%	8.2%	1.9%	4.8%	10.8%	6.8%
more than 5 times per week	60.2%	62.3%	81.9%	81.0%	80.4%	87.5%
I. Number of times HH eats fruits per week						
none	9.1%	15.0%	57.1%	68.2%	11.6%	11.5%
once a week	32.5%	20.0%	22.9%	14.3%	27.2%	26.4%
2 - 3 times per week	33.8%	45.0%	5.7%	-	29.9%	32.2%
4 - 5 times per week	7.8%	5.0%	-	1.6%	8.8%	10.3%
more than 5 times per week	16.9%	15.0%	14.3%	15.9%	22.4%	19.5%
J. Number of times HH eats canned goods per week						
none	4.9&	11.5%	38.1%	42.9%	21.2%	19.3%
once a week	45.1%	31.1%	33.3%	33.3%	62.9%	53.4%
2 - 3 times per week	43.9%	52.4%	15.2%	3.2%	14.6%	22.7%
4 - 5 times per week	4.9%	4.9%	-	3.2%	0.7%	1.1%
more than 5 times per week	1.2%	-	13.3%	17.5%	0.7%	3.4%

water use. Around 2/3 of them use electricity for their lighting and over 4/5 have access to piped- or pumped-water in or near their houses. The Visayas households come in second, while the Mindanao households are the most disadvantaged group. Lacking electricity and potable water sources, over 2/3 of the Mindanao households depend on kerosene and oil for their lighting, while over 20% report collecting their water from rain or spring sources.

Regardless of region, the great majority of families use wood for their cooking. The prevalent use of firewood owes in part to the local availability of fuelwood, as well as to the high cost of modern cooking facilities which poor families cannot afford. In all 3 regions, fewer than 10% of households have more convenient cooking facilities that make use of LPG or kerosene.

Finally, in terms of household sanitation facilities, the Luzon respondent-households (who are also more favored with water supply) are better equipped with toilet facilities, followed by the households in Mindanao. In the Visayas however, as many as 30% to 40% of households have no toilet facility of whatever kind, despite the greater availability of water in their region than in Mindanao. The Visayas households further differ from their Luzon and Mindanao counterparts in their garbage disposal practices. Whereas households in Luzon and Mindanao commonly burn or compost their garbage, those in the Visayas report simply dumping their garbage outside of their houses. Although toilet and garbage disposal practices are treated here as indicators of the socioeconomic status of households, these also reflect areas that can be influenced by community-based health programs. Hence, it may be instructive for the programs and for CHWs to note the still considerable incidence of households with no or unsanitary toilet facilities and garbage disposal practices. Considering that the incidence of these households constitute a substantial 20% or more in some localities, CHW sanitation campaigns can result in further community health improvement.

Household Diets and Nutrition

Because most households engage in subsistence agricultural activites, household diets and nutrition depend on the kinds and quantities of food that families produce. Hence, except for the Visayas households that live in relatively more urban places and fewer of which are engaged in farming, households in Luzon and Mindanao depend largely on rice that they themselves produce. Fewer than a fourth of the Luzon and Mindanao households therefore, report buying their rice, in contrast to a much higher 80% of the Visayas households that depend on the market for their rice requirements. Nonetheless, although households in Luzon and Mindanao produce rice, there are indications that their harvests are not always sufficient for their needs. Not a few households, particularly in Luzon, report shifting to rootcrops and/or bananas during certain months of the year when their own rice produce have run out.

In addition to rice, Table 4 also shows that households grow other foods to supplement their food intakes. Over 70% of households, for example, grow vegetables (usually consisting of "gabi", "malunggay, and "kangkong"), while generally over 50% of families report raising some chicken and pigs each year. Again, the exceptions are the Visayas households whose more urbanized surroundings may not easily allow them to engage in backyard crop production.

Table 6. Data on usual breakfast, lunch and dinner intakes of households by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. HHs' breakfast intake last week						
hot drink only (coffee/ chocolate only)	-	1.6%	1.9%	-	0.6%	-
bread, rice, lugaw only, or rice and noodles or rice and salt	1.2%	4.9%	18.1%	7.9%	8.6%	6.8%
hot drink with bread or rice	21.4%	8.2%	20.0%	20.6%	0.6%	1.1%
rice and vegetable (with or without coffee)	-	3.3%	-	1.6%	9.2%	3.4%
rice and eggs (with or without coffee)	14.3%	9.8%	2.9%	9.5%	0.6%	2.3%
rice and fish (with or without coffee)	6.0%	24.6%	41.9%	50.8%	33.6%	25.0%
rice with vegetable and fish or vegetable and meat or fish and meat	22.6%	16.4%	5.7%	7.9%	23.7%	29.5%
rice with vegetable, fish and meat or 3 or more food items	34.5%	31.1%	9.5%	1.6%	23.0%	31.8%
B. HHs' lunch intake last week						
rice or noodles only or rice and noodles	1.2%	-	3.8%	-	2.0%	1.1%
rice and vegetable	56.1%	55.7%	3.8%	3.2%	29.6%	19.3%
rice and fish	8.5%	16.4%	16.2%	17.6%	10.5%	14.8%
rice with vegetable and fish or vegetable and meat or fish and meat	23.2%	23.0%	65.7%	73.0%	46.7%	46.6%
rice with vegetable, fish and meat or 3 or more food items	11.0%	4.9%	10.5%	6.3%	11.2%	18.2%
C. HHs' dinner intake last week						
rice or noodles only or rice and noodles	1.2%	-	1.0%	-	0.6%	-
rice and vegetable	31.3%	31.1%	4.8%	4.8%	22.4%	19.3%

Table 6 (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
rice and fish	20.5%	24.6%	28.6%	28.6%	25.7%	14.8%
rice with vegetable and fish or vegetable and meat or fish and meat	30.1%	31.1%	53.3%	60.3%	44.1%	50.0%
rice with vegetable, fish and meat or 3 or more food items	16.9%	13.1%	12.4%	6.3%	7.2%	15.9%
D. Percent of HHs saying its food intake is						
more than adequate	3.6%	5.0%	1.0%	-	12.5%	12.5%
adequate	77.1%	78.3%	71.4%	90.5%	75.0%	70.5%
less than adequate	19.3%	16.7%	27.6%	9.5%	12.5%	17.0%
E. Percent of HHs saying its food intake is						
highly nutritious	3.6%	6.6%	3.8%	3.2%	2.0%	1.1%
moderately nutritious	79.5%	82.0%	55.2%	74.6%	63.5%	63.6%
low in nutritional value	16.9%	11.5%	41.0%	22.2%	34.5%	35.2%

Table 7. Data on households' access to health facilities/services by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Location of hospital nearest to HH						
within the barangay	1.2%	6.6%	-	-	2.6%	8.0%
in another barangay	25.3%	14.8%	88.6%	92.1%	64.5%	61.4%
in another municipality	73.5%	78.7%	11.4%	7.9%	27.6%	30.7%
in another province	-	-	-	-	5.3%	-
B. Distance from R's house to hospital						
1 - 2 kilometers	5.9%	-	44.8%	39.7%	20.4%	26.1%
3 - 4	9.8%	-	22.9%	20.6%	7.2%	13.6%
5 - 6	-	5.7%	17.1%	15.9%	7.9%	8.0%
7 or more	84.3%	94.3%	15.2%	23.8%	64.5%	52.3%
Mean	41.3	48.3	4.2	4.3	7.8	8.2
C. Whether HH has availed of hospital services						
No	32.5%	49.2%	33.3%	31.7%	53.3%	46.6%
Yes	67.5%	50.8%	66.7%	68.2%	46.7%	53.4%
D. Percent of HHs saying they visited the local hospital in the:						
(N= only among HHs availing of hospital services)						
last 1 - 12 months	74.5%	76.7%	61.5%	74.5%	54.9%	76.6%
last 13 - 24	9.1%	10.0%	15.7%	11.6%	19.7%	8.5%
last 25 - 60	9.1%	10.0%	11.4%	11.6%	12.7%	8.5%
over 60 or 5 years ago	7.3%	3.3%	11.4%	2.3%	12.7%	6.4%
E. Purpose of HH's last visit to hospital						
consultation due to illness	78.2%	77.4%	85.7%	90.7%	66.2%	63.8%
for pre-natal consultation	3.6%	3.2%	4.3%	4.6%	1.4%	2.1%
for childbirth/delivery	9.1%	16.1%	8.6%	4.6%	4.2%	8.5%
hospitalized due to illness	9.1%	3.2%	1.4%	-	28.2%	23.4%
for immunization	-	-	-	-	2.1%	
F. Location of RHU nearest to HH						
within barangay	51.8%	52.5%	41.0%	34.9%	74.3%	73.9%

Table 6. (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
in another barangay	28.9%	26.2%	53.3%	60.3%	25.7%	26.1%
in another municipality	19.3%	21.3%	5.7%	4.8%	-	-
G. Distance of R's house to nearest RHU						
less than a kilometer	13.0%	15.2%	35.2%	23.8%	25.2%	28.4%
1 - 2 kilometers	13.0%	21.2%	61.9%	73.0%	38.4%	42.0%
3 - 4	4.3%	3.0%	-	1.6%	30.6%	26.1%
5 or more	69.6%	60.6%	2.9%	1.6%	6.0%	3.4%
H. Percent of HHs saying they visited the RHU in the:						
last 1 - 12 months	37.0%	24.6%	33.3%	42.9%	57.2%	68.2%
last 13 - 24	6.2%	3.3%	2.9%	1.6%	7.9%	2.3%
last 25 - 60	4.9%	3.3%	-	-	3.9%	4.6%
over 60 months or 5 years ago	-	1.6%	4.8%	1.6%	3.3%	3.4%
never visited the RHU	51.9%	67.2%	59.0%	54.0%	27.6%	21.6%
I. Purpose of last visit to RHU (N= only among HHs availing of RHU services)						
consultation due to illness	47.4%	55.0%	86.0%	86.2%	50.9%	47.8%
for pre-natal consultation	5.3%	10.0%	2.3%	10.3%	20.0%	13.0%
for childbirth/delivery	10.5%	20.0%	-	-	25.4%	37.7%
for immunization	34.2%	10.0%	11.6%	3.4%	2.7%	-
for FP services	2.6%	5.0%	-	-	0.9%	1.4%
J. Whether there are private clinics/doctors in the barangay						
None	68.7%	72.6%	93.3%	93.6%	78.9%	75.0%
Yes	31.3%	27.4%	6.7%	6.3%	21.1%	25.0%
K. Whether HH had consulted private clinic/doctor						
No	57.2%	88.2%	42.9%	100.0%	31.2%	45.4%
Yes	42.8%	11.8%	57.1%	-	68.8%	54.6%
L. Percent of HHs saying they consulted the private clinic/doctor in the:						
last 1 - 12 months	38.5%	-	42.9%	-	65.6%	50.0%

Table 6 (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
last 13 - 24	-	-	14.3%	-	3.1%	4.5%
never consulted	57.7%	88.2%	42.9%	100.0%	31.2%	45.4%
dk/na	3.8%	11.8%	-	-	-	-
M. Purpose of last consultation						
consultation due to illness	100.0%	100.0%	100.0%	-	95.4%	91.7%
for immunization	-	-	-	-	4.5%	8.3%
N. Whether there is a government-trained BHW in the barangay						
None	33.7%	66.1%	48.6%	38.1%	27.0%	38.6%
Yes	66.3%	33.9%	51.4%	61.9%	73.0%	61.4%
O. Nature of R's contact with the BHW						
had no contact with the BHW	26.4%	85.7%	66.7%	74.4%	31.5%	53.7%
attended nutrition/health/ mothers' classes/meetings/ seminars held by BHW	47.2%	4.8%	18.5%	20.5%	17.1%	9.2%
home visits	26.4%	9.5%	7.4%	2.6%	39.6%	22.2%
weighing of children	-	-	3.7%	-	9.9%	11.1%
for FP check up/classes/ information	-	-	3.7%	2.6%	1.8%	3.7%

Least engaged in food production, the Visayas households expectedly buy most of their food requirements. Other than rice, the food items they commonly buy are fresh/dried fish (over 90%), and vegetables (over 50%). The Luzon and Mindanao households use their cash instead to buy "bagoong" (salted fish/shrimp paste - 50%), and coffee and sugar (over 90%). In Mindanao, households are more likely to buy fish (over 88%), and also "bagoong" (around 50%).

Although the survey included questions on the amount of rice and the frequency with which households consume certain kinds of food, these do not offer us sufficient basis for gauging the adequacy and quality of household diets. Table 5 which presents some of these data shows considerable differences in the kinds of food eaten by households that may partly reflect differences in regional food preferences and the varying incomes of households. But given their low incomes and the fact that the food produced by households is similarly limited, it is not unlikely that, like other poor Filipinos, the food intakes of the survey households are below acceptable nutritional standards.

On the average, households report consuming between 15 to 16 kilos of rice per week (see Table 5). This amount does not seem much, considering that families have 6 or more members, many of whom are engaged in heavy agricultural work and other manual activities. Next to rice, the foods most commonly consumed by households are vegetables and "bagoong" which over 50% of households report eating daily or at least 4 to 5 times a week. The next commonly consumed items are fresh/dried fish and eggs, usually eaten by households at least 2 to 3 times a week. On the other hand, chicken, pork and other meat are a luxury to most households, the majority consuming these items only once a week. Fruits and canned goods are also not commonly part of household diets. Typically, these items are consumed only a few times a week.

Respondents were further asked to describe their typical meals in the previous week, to see whether the foods they ate offered sufficient sources of energy, protein, vitamins, and other minerals and elements that the body needs. Here, the data again show some differences across, as well as within regions (see Table 6). In general, Luzon households tend to be vegetable-eaters compared to the Visayas households which seem to prefer fish, and the Mindanao households which tend to have generally more varied diets.

In terms of usual breakfast fares, both the Luzon and Mindanao households eat more varied breakfasts, as around half of them have rice and at least 2 other kinds of food consisting of vegetables, and fish or meat. Among Visayas households, breakfasts commonly consist of just rice and fish. In all regions however, there are households (ranging from 8% to 23%) whose breakfasts consist only of a hot drink (coffee) and rice or noodles or bread.

The Visayas households tend to make up for their limited breakfasts by having more varied lunches and dinners that consist of rice and 2 or more kinds of food made of vegetables, fish or meat. The Mindanao households are relatively more consistent in their diets having not only varied breakfasts but also varied lunches and dinners. The Luzon households, on the other hand, generally stick to rice and vegetables for lunch and have more kinds of foods at dinner time.

While the data suggest many households have quite varied diets, these do not enable us to arrive at conclusions regarding the adequacy and quality of household nutrition owing to difficulties in

collecting detailed information on the amounts or quantities of each food item eaten by households. Based on what is commonly known of the eating patterns of poor households however, the respondent-households probably consume large portions of rice with some salty food as ("bagoong" or dried fish) and some vegetables and limited quantities of all other kinds of food as fresh fish, meat, poultry and eggs. Meat, particularly, is not prepared as a separate dish but is cooked with a lot of soup or vegetables to make this go a longer way for family members.

The insufficiency of household nutrition and diets may also be reflected in the still substantial number of respondents who rate their usual food intakes to be less than adequate (from 12% to 28% in Table 6D), or to be low in nutritional value (12% to 41% in Table 6E). One notes, moreover, that the number saying their diets are adequate (possibly because these are filling to the stomach) is less than those saying their diets are nutritious -- indicating a recognition on the part of many households that their nutritional status remains in need of improvement.

Because community health workers do not always engage in socioeconomic work, they are not in a position to directly address food production- and income-concerns which are the most basic factors that influence household nutrition and health. Nonetheless, it may be important that, in addition to nutrition education, community-based health programs expand their efforts to improve on the production of food for home consumption. The data show that most households already engage in various food- growing activities but these may be unsystematically done at present. There may be room, therefore, for transforming backyard gardens and other subsistence activities into more organized efforts at growing grains, poultry, livestock and vegetables directed at increasing food for the consumption of families.

Household Access to Health Facilities

Expectedly, the more common health facility found in the survey communities is the Rural Health Unit (RHU). This is particularly true in Mindanao where a substantial 74% majority of the respondents say that the RHU nearest their place is located within their own barangays and generally, within 4 kilometers from where they stay (see Table 7). In the Visayas, the typical respondent-household has to go to another barangay in order to visit the RHU, although distance-wise, RHUs are not also located too far away from where the respondents live (also some 4 kilometers away). The Luzon households are least reached by RHUs: close to 50% of the respondent-households in the region report that the RHU nearest their area is located either in another barangay or in another municipality that is over 5 kilometers away from where they stay.

Government hospitals are seldom located in the same localities as those of the respondents', although there are again differences in the regions' access to these facilities. As with the RHUs, the Mindanao and Visayas households are more favored: hospitals are some 7 to 8 kilometers away from the Mindanao respondent-households and around 4 kilometers away from the Visayas households. In contrast, to get to the nearest government hospital, Luzon households have to travel a much longer distance averaging over 40 kilometers from their houses or communities.

Table 8a. Data on the incidence of illness, infant deaths, and disabilities among household members by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Percent of HHs experiencing serious illness in the last 12 months						
no family member was seriously ill	48.8%	59.0%	79.0%	77.8%	58.6%	65.9%
1 member was seriously ill	35.7%	31.1%	15.2%	17.5%	33.6%	25.0%
2 members were seriously ill	8.3%	8.2%	4.8%	4.8%	5.9%	6.8%
3 or more members were seriously ill	7.1%	1.6%	1.0%	-	2.0%	2.3%
B. Percent of serious illness accounted for by:						
children under 6 years old	7.9%	21.9%	34.5%	23.5%	30.0%	14.3%
7 - 12	14.3%	18.8%	27.6%	23.5%	7.5%	16.7%
13 - 16	9.5%	3.1%	6.9%	-	6.2%	4.8%
17 years old and over	68.2%	56.2%	31.0%	52.9%	56.2%	64.3%
C. Percent of HHs experiencing minor illness last month						
no member got sick of any minor illness	25.0%	29.5%	20.0%	15.9%	16.4%	10.2%
1 - 2 members afflicted with minor illness	63.1%	62.3%	65.7%	66.7%	70.4%	65.9%
3 - 4 members afflicted with minor illness	11.9%	6.6%	11.4%	15.9%	7.9%	14.8%
5 - 6 members afflicted with minor illness	-	1.6%	1.9%	-	3.3%	5.7%
more than 6 members afflicted with minor illness	-	-	1.0%	1.6%	2.0%	3.4%
D. Percent of minor illness accounted for by:						
children under 6 years old	41.3%	50.0%	62.0%	56.0%	50.7%	54.1%
7 - 12	19.2%	23.4%	16.0%	18.7%	20.2%	24.0%
13 - 16	8.6%	7.8%	3.3%	4.4%	9.3%	6.2%
17 years old and over	30.8%	18.8%	18.7%	20.9%	19.8%	15.8%
E. Mothers' previous experience						

Table 8a (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
with infant/child deaths						
never had a child who died	73.8%	86.9%	69.5%	73.0%	71.7%	71.6%
with 1 infant/child death	13.1%	8.2%	18.1%	17.5%	19.1%	23.9%
with 2 infant/child deaths	9.5%	1.6%	7.6%	7.9%	6.6%	3.4%
with 3 infant/child deaths	3.6%	3.3%	2.9%	1.6%	0.7%	-
with 4 or more infant/child deaths	-	-	1.9%	-	2.0%	1.1%
F. Percent of HHs experiencing other deaths in the last 5 years						
with no other deaths	88.1%	96.7%	90.5%	96.8%	93.4%	94.3%
with 1 death	11.9%	1.6%	8.6%	3.2%	5.3%	5.7%
with 2 deaths	-	1.6%	1.0%	-	1.3%	-
G. Percent of HHs with a member suffering from a physical disability						
no member afflicted with disability	91.7%	96.7%	89.5%	96.8%	90.8%	93.2%
with a member afflicted with disability	8.3%	3.3%	10.5%	3.2%	9.2%	6.8%
H. Percent of Rs saying HH's health status is _____ than 5 years ago						
better now	46.4%	34.4%	58.1%	42,9%	44.7%	43.2%
same as before	36.9%	52.5%	36.2%	47.6%	40.1%	30.7%
worse off now	16.7%	13.1%	5.7%	9.5%	15.1%	26.1%
I. Percent of Rs saying HH's health status is _____ than others in the community						
better than others	31.0%	24.6%	29.5%	30.2%	24.3%	19.3%
same as others	59.5%	67.2%	64.8%	61.9%	63.8%	67.0%
worse than others	9.5%	8.2%	5.7%	7.9%	11.3%	13.6%

For the most part, there are no private clinics or medical doctors in the survey barangays. However, there tend to be government-trained barangay health workers (BHWs) stationed in the areas. Awareness of the local BHW runs over 50% in most of the survey communities and as high as 61% to 73% in Mindanao.

Even as there are some health facilities in the survey barangays and in surrounding areas, however, there are indications that households do not always avail of their services. Over half of the respondent-households in Luzon (52% to 67%) and in the Visayas (54% to 59%), for instance, have never visited the RHUs. RHUs are better utilized in Mindanao, in part because RHUs are located within the respondents' own barangays. In Mindanao, as many as 75% of the households report having availed of the RHU services at least once in the last 5 years.

Between RHUs and government hospitals, Luzon and Visayas households tend to patronize hospitals more than local RHUs. Still however, a substantial third of households in these regions and a higher half of the Mindanao households (who tend to use the RHUs) have never gone to the hospital for any kind of consultation.

While some households are shown to consult private clinics and medical doctors, the absence of these health facilities and personnel in most of the survey areas already limits their reach to the local population. On the other hand, of the larger number of survey households admitting to the presence of BHWs in their communities, the Visayas households are least likely to avail of the BHW's services (67% to 74% have had no contact with local BHWs) compared to those in Luzon and Mindanao. On the whole, patterns of health services-availment show that the Mindanao households more frequently consult or visit local RHUs and BHWs, whereas those in Luzon and Visayas tend to skip the RHU and prefer to use the services of government hospitals that are farther away from their communities.

Regardless of region, most of the households who report having visited a health facility have done so in the last 12 months and usually for consultations regarding a household member's illness. Not too many households visit health facilities for pre-natal consultations, childbirths or deliveries, child immunization, and for family planning advice and services. Expectedly however, each health facility offers certain special services: hospitalization for illneses by hospitals, childbirths or deliveries by RHUs, and nutrition/health education and home visits by BHWs.

Briefly summarizing the major points from the data on household access to health facilities, we note first, that RHUs are the common health facilities found in the survey areas. Government hospitals, and private clinics, and doctors are less common and therefore, also less frequently availed of by households. Second, there are regional differences in the use of health facilities. In general, Mindanao households are greater users of locally available RHUs and BHWs. In Luzon and Visayas, households tend to go to hospitals for their health needs. Third, in all regions, there remain a considerable number of households not easily reached by RHUs, since the Philippine government has yet to realize its goal of universally bringing barangays within the coverage of RHUs. Fourth and finally, there are indications that households do not fully utilize the services of existing health facilities.

Table 8b. Data on the nature of serious and minor illnesses, causes of child and other deaths, and nature of disabilities by served and unserved and by region.

	SERVED (N)	UNSERVED (N)	TOTAL (N)	(%)
A. Nature of serious illnesses				
Luzon				
Pneumonia	11	6	17	19.3
Asthma	7	8	15	17.0
Diarrhea	5	5	10	11.4
Anemia	8	2	10	11.4
Malaria	7	2	9	10.2
Influenza	8	1	9	10.2
Tuberculosis	6	2	8	9.1
Heart disease	3	1	4	4.5
Kidney trouble	2	1	3	3.4
Cancer	2	1	3	3.4
Visayas				
Influenza	15	5	20	44.4
Asthma	3	2	5	11.1
Diarrhea	2	3	5	11.1
Pneumonia	3	1	4	8.9
Heart disease	2	2	4	8.9
Tuberculosis	2	1	3	6.7
Cancer	-	2	2	4.4
Kidney trouble	1	-	1	2.2
Fever	-	1	1	2.2
Mindanao				
Malaria	55	22	77	23.2
Diarrhea	44	22	66	19.9
Influenza	44	6	50	15.1
Pneumonia	25	3	28	8.4
Tuberculosis	22	6	28	8.4
Kidney trouble	22	6	28	8.4
Wounds	22	-	22	6.6
Asthma	16	-	16	4.8
Heart disease	11	3	14	4.2
Deafness	-	3	3	0.9
B. Nature of minor illness				
Luzon				
Cough	46	28	74	45.4
Fever	24	20	44	27.0

Table 8b. (cont'd)

	SERVED (N)	UNSERVED (N)	TOTAL (N)	(%)
Diarrhea	17	8	25	15.3
Scabies	5	4	9	5.5
Measles	4	3	7	4.3
Anemia	3	1	4	2.4
Visayas				
Cough	81	38	119	48.2
Influenza	39	31	70	28.3
Diarrhea	12	11	33	13.4
Fever	13	9	22	8.9
Anemia	2	-	2	0.8
Scabbies	1	-	1	0.4
Mindanao				
Cough	281	121	402	36.1
Influenza	165	162	327	29.3
Diarrhea	118	44	162	14.5
Fever	127	22	149	13.4
Sore eyes	41	-	41	3.7
Heart disease	11	-	11	1.0
Scabbies	6	3	9	0.8
Wounds	6	-	6	0.5
Kidney trouble	-	5	5	0.4
Malaria	-	3	3	0.3
C. Causes of infant/ child deaths				
Luzon				
Pre-mature	-	1	1	3.3
Starvation	2	-	2	6.7
Accident	-	1	1	3.3
Pneumonia	14	2	16	53.3
Tetanus	3	2	5	16.7
Diarrhea	1	1	2	6.7
Heart disease	1	1	2	6.7
Fever	1	-	1	3.3
Visayas				
Pre-mature	-	1	1	2.1
Drowning	-	1	1	2.1
Pneumonia	18	9	27	57.4
Diarrhea	3	6	9	19.1
Tetanus	4	1	5	10.6

Table 8b. (cont'd)

	SERVED (N)	UNSERVED (N)	TOTAL (N)	(%)
Meningitis	2	1	3	6.4
Ear infection	1	-	1	2.1
Mindanao				
Pre-mature	10	3	13	8.9
Accident	3	-	3	2.1
Pneumonia	47	23	70	47.9
Diarrhea	29	6	35	24.0
Heart disease	5	6	11	7.5
Fever	3	6	9	6.2
Tetanus	5	-	5	3.4
D. Causes of other deaths				
Luzon				
Accident	1	-	1	9.1
Old age	1	-	1	9.1
Tuberculosis	2	1	3	27.3
Heart disease	3	-	3	27.3
Diarrhea	1	-	1	9.1
Cancer	1	-	1	9.1
Tetanus	1	-	1	9.1
Visayas				
Heart disease	1	4	5	45.4
Tuberculosis	3	-	3	27.3
Diarrhea	2	-	2	18.2
Meningitis	-	1	1	9.1
Mindanao				
Old age	8	3	11	23.9
Accident	3	-	3	6.5
Tuberculosis	5	6	11	23.9
Fever	10	-	10	21.7
Diarrhea	5	-	5	10.9
Heart disease	3	-	3	6.5
Cancer	3	-	3	6.5
E. Nature of physical disabilities				
Luzon				
Deaf	2	1	3	33.3
Harelip	3	-	3	33.3

Table 8b. (cont'd)

	SERVED (N)	UNSERVED (N)	TOTAL (N)	(%)
Lame	2	-	2	22.2
Polio	-	1	1	11.1
Visayas				
Blind	2	1	3	23.1
Lame	1	2	3	23.1
Fracture	1	1	2	15.4
Harelip	1	1	2	15.4
Deaf	1	-	1	7.7
Mute	1	-	1	7.7
Polio	-	1	1	7.7
Mindanao				
Lame	8	9	17	30.9
Deaf	10	-	10	18.2
Polio	8	-	8	14.5
Fracture	3	3	6	10.9
Mongoloid	-	6	6	10.9
Harelip	5	-	5	9.1
Blind	3	-	3	5.4

The last finding above is not entirely unexpected. Other studies have found that government facilities, even when made available, are not always used by households. In addition to distance from a facility, studies report that families face several other attitudinal, financial and structural constraints in using or "accessing" government services. In the case of health facilities, it has been reported that some families are reluctant to visit these because of their non-familiarity with or apprehension over modern medical technologies, the patronizing attitudes of medical personnel, or because the treatment or medicines prescribed by existing health services are beyond their financial reach. Primary health care programs, therefore, have been designed partly to fill in some of these gaps in local health care provision, through a program more adapted to the local culture and economic conditions of households. In this sense, the survey data indicate a continuing relevance of community-based health care programs in Philippine rural communities. But considering the generally limited resources and personnel of community-based health programs, these programs should probably consider enhancing the role of primary health workers as "linkages" between families and locally available health facilities. Community health workers as well as barangay health workers, for example, can assume a more active "role" in referring families to other health facilities for the treatment of major illnesses, the immunization of children, family planning, and for all other such cases that they themselves cannot easily or readily handle.

III. The Prevalence of Illnesses, Deaths and Disabilities Among Household Members

Although incidences of morbidity, mortality and disabilities among family members are generally accepted as measures of household health, there are as yet no standard procedures for estimating these health measures from surveys.

The country's national health statistical system continues to be based primarily on the administrative records maintained by government hospitals and health centers. These are, thus, limited to the illnesses and deaths reported to these facilities and are not readily comparable with those reported in surveys. Moreover, determining whether a family is "sickly" or "healthy" requires information on the personal histories of family members, as well as on their age, sex, occupation and other factors that are known to influence a person's health. Most of these detailed information are difficult to collect in general health surveys.

For the most part therefore, survey data on the frequency and nature of illnesses and the incidence of deaths and disabilities are used largely to describe ongoing trends and the overall patterns of illnesses in given localities. These are also seen and analyzed against the socioeconomic backgrounds of communities. As with many other rural communities in the Philippines, the discussion in the preceding section shows that the CBHP areas covered in the present study are beset by problems that adversely affect the health of families. Characterized by limited incomes and poor

harvests, inadequate nutrition and the continuing lack of basic services, the socioeconomic conditions obtaining in the study areas are generally inhospitable to the promotion of household health.

Prevalence of Serious Illnesses

The data presented in Table 8A suggest a relatively high incidence of illnesses among household members. Even major or serious illnesses are not infrequent occurrences among families. In the Visayas, over 20% of households had a family member afflicted with a serious illness in the year immediately preceeding the survey. The comparable figures for Mindanao are a higher 34% to 41%, and are highest in Luzon where as many as 41% to 51% of households had at least 1 family member who was seriously ill in the previous year. In all regions, serious illnesses tended to afflict older family members (17 years and over), although in the Visayas, children under 6 years old accounted for a substantial 23% to 34% of the major illnesses suffered by family members.

The nature of serious illnesses reported by households varies by region (see Table 8B). In Luzon, the leading diseases include respiratory-related problems (pneumonia and asthma), followed by gastrointestinal cases (diarrhea) and malnutrition (anemia). Malaria, flu, and TB each accounted for a lower 10% of serious illnesses, while heart disease, kidney problems and cancer are the least common serious illnesses affecting households in the region. Mindanao, however, says much of the conditions of survey communities in the region, considering that malaria has been controlled and is no longer a leading illness nationally. On the other hand, "flu", the leading illness reported by the Visayas households is also likely related to respiratory and gastrointestinal disorders.

In Mindanao, the most prevalent serious illness is malaria which accounted for 23% of all illnesses in the previous year, followed by diarrhea (20%) and "flu" (15%). Fewer families were afflicted with other diseases like pneumonia, TB and kidney trouble, although the ongoing insurgency conflict in the region appears to have taken its toll on Mindanao households. Some 6% of the serious illnesses suffered by households in the previous year were due to wounds and injuries sustained from the counter- insurgency related operations in the region.

In the Visayas, which also exhibits the lowest incidence of serious illnesses, the most common serious illness reported by households is "flu" which, because it was characterized by high and prolonged fever, was considered by respondents as serious. Flu accounted for as much as 44% of major illnesses, while all others as asthma, diarrhea, pneumonia and others each accounted for no more than 11% of all illnesses.

The foregoing patterns of serious illnesses, and particularly that of the Luzon households, generally conform with the known leading diseases in the Philippines which are related to respiratory and gastrointestinal disorders. The fact that malaria continues to be the leading major illness in Mindanao, however, says much of the conditions of survey communities in the region, considering that malaria has been controlled and is no longer a leading illness nationally. On the other hand, "flu," the leading illness reported by the Visayas households is also likely related to respiratory and gastrointestinal disorders.

Incidence of Minor Illnesses

Understandably, minor illnesses occur even more frequently than major illnesses. In the last month alone, at least 75% of the Luzon households, and 80% and 85% of the Visayas and Mindanao households respectively, had one or more of their members who was ill of the minor ailment.

Patterns of minor illnesses are also much more consistent across regions. Minor illnesses were more likely to afflict young children than the older members of the households. In Luzon, children under 6 years old accounted for 41% to 50% of minor illnesses, and a higher 51% to 54% in Mindanao, and 56% to 62% in the Visayas. In all 3 regions, the top three most common minor illnesses reported by households were cough, diarrhea, and either flu or fever. An outbreak of sore eyes most likely occurred in some of the Mindanao communities increasing incidence of the disease as the fifth-ranking in the region. The other minor ailments common to the regions are scabies and anemia.

As with the nature of serious illnesses, those of minor illnesses are again related to gastrointestinal and respiratory problems, many of which are communicable and can be controlled with community and household sanitation, as well as with improved nutrition.

Deaths and Disabilities Among Household Members

In view of the known risks of infants, most of the deaths occurring in households are those of infants and children. Except for the unserved households in Luzon where an atypically low 14% of mothers report never having experienced a child death, the proportions of mothers who have had at least one child death range from 26% in Luzon, to 28% in Mindanao, and 27% to 30% in the Visayas. These figures fall within the 25% to 30% estimates of families experiencing infant/child losses reported in other surveys of poor households. While the above figures cannot be translated to measures of infant/child death rates, we have no reason to believe that infant/child mortality in the study barangays would be lower than the high nationally estimated infant mortality rate or IMR of 60 to 80 deaths per 1000 (live births). In fact, given the poor socioeconomic and health conditions in the survey areas, it is not unlikely that the incidence of infant and child deaths in these would be higher than the national average.

Usually, families who have had children dying would have experienced only one infant or child death, although there are other less fortunate households who have had to deal with repeated infant/child death experiences. The leading cause of early deaths in all 3 regions is pneumonia, followed by diarrhea in both Visayas and Mindanao, and tetanus in Luzon (see Table 8B). Tetanus also claimed the lives of some children in the Visayas, while some mothers in Luzon had children who died of starvation. In themselves, the causes of early deaths offer a statement of the economic difficulties of families and the poor state of physical well-being in the study communities.

Deaths among older family members are less frequent. In general, less than 10% of households lost an adult member in the last 5 years. Most adult deaths were caused by tuberculosis, this disease ranking first in Luzon and Mindanao and second in the Visayas. Heart diseases claimed just as many lives in Luzon as tuberculosis. Already eradicable, the prevalence of tuberculosis-related deaths again reflect the poor health and economic conditions of the survey localities.

Physical disabilities generally afflict between 7% to 11% of the households, except for the unserved households in Luzon and the Visayas where only 3% of families report that they have a disabled family member. As with the incidence of early deaths, the prevalence of physical disabilities in the survey communities probably does not differ too much from the estimates given by other agencies and groups engaged in assisting persons with disabilities, which is around 10% of the population of local communities. The more common disabilities affecting family members are deafness and harelip in Luzon, blindness and lameness in the Visayas, and lameness and deafness in Mindanao.

Finally, when asked to rate their household's present health status in relation to 5 years ago and vis-a-vis other households in their communities, respondents do not feel particularly disadvantaged. The majority of respondents in all regions (59% to 67%) felt that their family's health status is similar to those of other families; while another 19% to 31% felt that health-wise, they are better off than other households. Many more families however, seem to feel that compared to 5 years ago, their health status has improved. This is more true in Mindanao where the plurality of responses for both served and unserved households center on the "better now" category (43% to 45%) rather than on "same as before" (31% to 40%). In Luzon and the Visayas, patterns are less consistent: more of the served households say their family's health status has improved since 5 years ago (46% to 58%), while unserved households generally felt theirs did not change too much from before (48% to 52%). That only a few families felt their health is getting worse or is worse than others, suggests no drastic or serious deterioration in the health of families. The prevalence and nature of illnesses in the survey areas however, reveal still many areas for upgrading the health of communities and households.

III. Other Household Health Indicators and Practices

Incidence and Patterns of Health Consultations

The survey results shown in Table 9 indicate that households seek health or medical assistance and advice on various occasions, and that their choice of whom to consult depends on the nature of illnesses and medical needs of their family members.

In general, households are more likely to seek medical advice and assistance in times of serious illnesses, during childbirths or deliveries, and for family planning. The proportions of families not

Table 9. Patterns of health-seeking behavior by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Percent of HHs consulting _____ for serious illness						
no one	2.3%	-	-	14.3%	3.2%	6.7%
relatives/neighbors	2.3%	-	-	-	7.9%	3.3%
hilot/herbolario	-	-	-	-	9.5%	13.3%
CHW	20.9%	-	9.1%	-	14.3%	-
BHW	-	-	-	-	1.6%	6.7%
midwife	2.3%	4.0%	-	-	3.2%	3.3%
nurse	2.3%	-	-	-	-	-
doctor	79.1%	96.0%	95.4%	85.7%	65.1%	66.7%
B. Percent of HHs consulting _____ for minor illness						
no one	11.1%	18.6%	24.4%	41.8%	22.8%	26.3%
relatives/neighbors	3.2%	9.3%	2.4%	3.6%	13.4%	14.5%
hilot/herbolario	3.2%	11.6%	6.1%	1.8%	4.7%	7.9%
CHW	55.6%	-	40.2%	-	39.4%	-
BHW	1.6%	4.6%	-	12.7%	1.6%	-
midwife	3.2%	7.0%	-	1.8%	6.3%	9.2%
nurse	-	-	6.1%	1.8%	-	-
doctor	42.9%	58.1%	31.7%	45.4%	40.9%	42.1%
C. Percent of mothers consulting _____ for pre-natal care/advice						
no one	29.8%	26.2%	-	-	20.4%	23.9%
relatives/neighbors	-	-	-	-	-	1.1%
hilot/herbolario	-	-	3.2%	11.8%	11.8%	11.4%
CHW	4.8%	-	10.8%	-	1.3%	-
BHW	-	-	-	23.5%	-	1.1%
midwife	20.2%	19.7%	28.0%	5.9%	49.3%	44.3%
nurse	-	-	10.8%	9.8%	1.3%	1.1%
doctor	45.2%	54.1%	47.3%	49.0%	15.8%	17.0%
D. Percent of mothers assisted by _____ at birth/delivery						
no one	1.2%	-	-	-	0.7%	-

Table 9 (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
relatives/neighbors	-	-	-	1.6%	6.0%	3.4%
hilot/herbolario	50.0%	49.2%	47.6%	54.1%	58.3%	74.7%
CHW	2.4%	-	15.5%	-	8.6%	-
BHW	-	-	-	14.8%	3.3%	9.2%
midwife	34.1%	35.6%	7.8%	-	14.6%	8.0%
nurse	1.2%	1.7%	1.0%	-	0.7%	-
doctor	11.0%	13.6%	28.2%	29.5%	7.9%	4.6%
E. Percent of mothers consulting _____ for post natal care						
no one	63.1%	78.7%	23.8%	23.8%	66.9%	63.6%
relatives/neighbors	-	3.3%	-	-	3.3%	2.3%
hilot/herbolario	-	-	-	-	0.7%	-
CHW	7.1%	-	22.9%	-	4.0%	-
BHW	-	-	-	31.7%	-	6.8%
midwife	6.0%	3.3%	1.9%	4.8%	18.5%	17.0%
nurse	1.2%	-	16.2%	20.6%	-	1.1%
doctor	22.6%	14.8%	35.2%	19.1%	6.6%	9.1%
F. Percent of mothers obtaining FP information from _____						
no one	5.1%	18.5%	2.7%	4.2%	4.2%	5.1%
relatives/neighbors	15.4%	14.8%	8.3%	25.0%	29.6%	20.5%
CHW	2.6%	-	2.8%	-	5.6%	-
BHW	-	-	11.1%	20.8%	-	12.8%
midwife	56.4%	48.1%	47.2%	33.3%	25.4%	17.9%
nurse	7.7%	14.8%	5.6%	12.5%	23.9%	33.3%
doctor	12.8%	3.7%	22.2%	4.2%	11.3%	10.3%

consulting anyone when a member is seriously ill are a low 2% to 14%, whereas virtually all mothers and households seek the assistance of someone for deliveries. Most mothers also report having sought advice on family planning, the proportions not having done so being generally less than 6%, except among the unserved households in Luzon where the comparable figure is a much higher 18%. As might have been expected, households prefer consulting medical doctors for serious illnesses; the "hilots" or traditional birth attendants for child deliveries; and midwives and relatives or neighbors for family planning.

In contrast, households are less likely to go for medical consultations in cases of minor illnesses, and for pre- and post natal consultations. Between 11% to as high as 42% of families across the regions report not consulting anyone for minor illnesses, while the proportions of mothers not consulting for prenatal and postnatal care are similarly substantial at 20% to 30% for prenatal care, and 24% to 67% for postnatal care. There are some regional differences in the magnitude of household non- consultations. Compared to mothers in Luzon and Mindanao for example, mothers in the Visayas are more conscious of seeking medical attention before and after their deliveries and hence, more of them report consulting health practioners for pre- and postnatal advice.

Among households consulting for minor illnesses, medical doctors are again generally preferred. In all 3 regions however, served households are increasingly turning to CHWs who now handle as many cases of minor illnesses as doctors in Mindanao, and slightly more cases than doctors in Visayas and Luzon. For pre- and postnatal care, mothers in Luzon and Mindanao continue to prefer a doctor's services, whereas in Mindanao, midwives are the chosen resource for maternal care during pregnancies and after births.

Maternal Health

Most health studies consider the health of mothers as central to all efforts at improving the health of households and communities. This is because, as the bearers of children, the well-being of mothers has long-term implications on the health of babies and children. Moreover, because women take charge of the basic health-related functions of households (e.g., cooking and meal preparations, household cleanliness and sanitation, nursing sick members and so forth), it is not also difficult to see why the health of other family members depends on the health of mothers.

Although women face a range of gender-related health risks, measures of their health status center largely on their "maternal functions" (i.e., childbearing and childrearing), since the overwhelming majority of women in Third World countries like the Philippines eventually get married and have children. Hence, measures of women's health and well-being generally relate to their conditions during pregnancies, childbirths and soon after births.

In terms of pregnancies, the survey results show that mothers in Luzon have had 4 to 6 pregnancies on the average, while those in Visayas and Mindanao averaged a slightly lower 4 to 5 pregnancies (see Table 10). In all regions however, the proportions of mothers with several and

repeated (5 or more) pregnancies comprise at least a third of all mother-respondents. But mothers, at present, have fewer living children (4 to 5 in Luzon and 3 to 4 in Visayas and Mindanao) than that indicated by their number of pregnancies, owing partly to a still high incidence of infant and child deaths among families, and to a considerable incidence of prenatal losses among mothers.

Miscarriages account for most pregnancy losses and for some reason, particularly among the served household-sample where as many as 17% to 30% of mothers have had at least 1 miscarriage. The occurrence of abortions and stillbirths, on the other hand, generally account for less than 5% of pregnancies.

If the foregoing incidence of pregnancy losses suggest some deficiencies in the health of mothers, this may be partly because, as with minor illnesses, some mothers are not inclined to go for consultations during their pregnancies. The percentage of these mothers are a lower 9% to 14% in the Visayas but reach a higher 20% to 30% in Luzon and Mindanao (see Table 11). Of mothers going for prenatal consultations moreover, the greater number have done so no more than 3 times during their last pregnancy, except again in the Visayas where mothers appear more religious in attending to their prenatal check-ups.

Mothers who have gone for prenatal consultations are commonly advised to improve their diets by taking supplementary vitamins or eating nutritious food, although in Mindanao, an additional third of mothers have also been advised to have anti- tetanus injections. Still other mothers have been asked to moderate their physical activities or to do some exercise.

Most mothers however, claim they are unable to follow much of the advice given them during their pregnancy. This is particularly so in the case of taking nutritional supplements (either in the form of vitamins or eating nutritious food), which they cannot afford to buy in view of the meager incomes of their households. But even in cases where mothers are simply asked to moderate their activities or to do some exercise, mothers say these too are difficult to follow because no one is left to do their household chores or, simply lacking time from housework, they are unable to attend to themselves and comply with the health care advice given them during their pregnancy.

Turning next to the circumstances surrounding child deliveries, the data show that, consistent with national patterns, the majority of the mother-respondents give birth at home, and are commonly attended to by "hilots" (47% to 75%). Generally, less than 15% of mothers give b t in clinics and hospitals, except in the Visayas where closer to a third have given birth in hospitals. CHWs and BHWs are also shown to handle some child deliveries, although in most cases, these numbers are minimal. Across the 3 regions, the CHWs in the Visayas have attended to the most number of child deliveries (15%).

In Luzon, conditions surrounding childbirths may be more sanitary as suggested by the fact that over 80% of mothers say a pair of scissors was used to cut their baby's umbilical cord. In Visayas and Mindanao, the use of bamboo, blade and knife and banana frond is more prevalent. Considerable proportions of mothers in these regions (32% to 34%) report these were the instruments used to sever the umbilical cord during their last birth.

Table 10. Data on mothers' pregnancy- and birth-histories by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Total number of pregnancies						
with 1 - 2 pregnancies	12.0%	26.2%	23.8%	25.4%	24.3%	26.1%
with 3 - 4	31.3%	32.8%	26.7%	41.3%	30.9%	29.5%
with 5 - 6	25.3%	21.3%	21.0%	12.7%	18.4%	26.1%
with 7 - 8	14.5%	16.4%	13.3%	14.3%	13.8%	5.7%
with 9 pregnancies and over	16.9%	3.3%	15.2%	6.3%	12.5%	12.5%
Mean	5.6	4.3	5.0	4.1	4.9	4.6
B. Total number of living children						
none	-	-	2.9%	1.5%	0.7%	-
1 - 2 children	20.2%	31.1%	30.5%	38.5%	31.6%	40.9%
3 - 4	33.3%	36.1%	31.4%	33.8%	31.6%	28.4%
5 - 6	27.4%	18.0%	21.0%	18.5%	20.4%	13.6%
7 or more children	19.1%	14.8%	14.3%	7.7%	15.8%	17.0%
Mean	4.5	3.8	3.8	3.5	3.9	3.6
C. Total number of miscarriages						
none	76.2%	90.2%	70.5%	87.3%	82.9%	85.2%
1 miscarriage	14.3%	9.8%	19.1%	11.1%	12.5%	11.4%
2 or more miscarriages	9.5%	-	10.5%	1.6%	4.6%	3.4%
D. Total number of abortions						
none	95.2%	96.7%	98.1%	100.0%	99.3%	100.0%
1 abortion	2.4%	3.3%	1.9%	-	0.7%	-
2 abortions	2.4%	-	-	-	-	-
E. Total number of stillbirths						
none	98.8%	98.4%	100.0%	93.6%	95.4%	98.9%
1 stillbirth	1.2%	1.6%	-	6.3%	3.9%	1.1%
2 or more stillbirths	-	-	-	-	0.7%	-

Table 11. Related data surrounding R's prenatal, delivery and postnatal care during her last birth by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Number of months since R's last birth/delivery						
1 - 12 months ago	25.6%	35.0%	29.1%	39.3%	37.5%	36.4%
13 - 24	12.2%	10.0%	22.3%	16.4%	26.3%	19.3%
25 - 36	8.5%	3.3%	17.5%	18.0%	9.2%	17.0%
37 - 48	9.8%	15.0%	11.6%	8.2%	5.3%	6.8%
49 - 60	6.1%	3.3%	6.8%	6.6%	3.3%	2.3%
over 60	37.8%	23.3%	12.6%	11.5%	18.4%	18.2%
B. Percent of mothers who had sought pre-natal care	70.2%	73.8%	91.3%	83.6%	79.6%	76.1%
C. Frequency of consultation during pregnancy (N= only among mothers consulting for prenatal care)						
9 times or monthly	34.5%	31.1%	52.7%	37.2%	9.1%	7.5%
6 - 8 times	3.6%	6.6%	1.1%	3.9%	10.7%	7.5%
4 - 5 times	10.9%	4.4%	10.8%	11.8%	13.2%	20.9%
2 - 3 times	40.0%	37.8%	28.0%	23.5%	58.7%	41.8%
once only	10.9%	20.0%	7.5%	23.5%	8.3%	22.4%
D. Nature of pre-natal advice given R						
take vitamins	89.8%	91.1%	88.5%	79.2%	64.5%	77.6%
eat nutritious food	11.9%	22.2%	31.0%	22.9%	33.1%	31.3%
have anti-tetanus injection	-	-	8.0%	10.4%	34.7%	37.3%
do light chores only	17.0%	20.0%	27.6%	33.3%	14.0%	14.9%
do some exercise	-	-	4.6%	-	47.9%	34.3%
have regular check-up	-	-	3.4%	-	34.7%	19.4%
avoid long distance travels	-	-	-	4.2%	1.6%	1.6%
E. Incidence of mothers who were able to follow advices						
Percent following 1st advice	69.6%	97.2%	90.8%	89.6%	97.5%	95.4%
Percent following 2nd advice	93.3%	63.6%	97.8%	88.9%	89.5%	94.0%
Percent following 3rd advice	100.0%	80.0%	100.0%	100.0%	85.4%	93.1%

Table 11. (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
F. Reasons given by mothers who were unable to follow advice						
no money to buy vitamins/ nutritious food/for check-up	66.7%	20.0%	60.0%	75.0%	63.6%	14.3%
vomit/feels dizzy when vitamin is taken	41.7%	-	60.0%	25.0%	-	14.3%
nobody will do HH chores	-	80.0%	-	25.0%	18.2%	14.3%
difficult to follow	-	-	-	25.0%	63.6%	57.1%
G. Place of delivery						
at home	84.3%	86.9%	66.7%	72.1%	93.4%	90.9%
in a clinic	2.4%	-	1.0%	-	0.7%	-
in a hospital	13.2%	13.1%	32.4%	27.9%	5.9%	9.1%
H. Person who cut the baby's umbilical cord						
husband	1.2%	-	1.0%	-	5.3%	3.4%
hilot	50.0%	50.8%	45.6%	52.4%	65.1%	60.2%
CHW	2.4%	-	20.4%	-	9.9%	-
BHW	-	-	-	8.2%	-	14.8%
midwife	34.5%	34.4%	7.8%	-	12.5%	14.8%
nurse	4.8%	6.6%	3.9%	1.6%	0.7%	-
doctor	2.4%	4.9%	13.6%	29.5%	5.3%	5.7%
DK	4.8%	3.3%	7.8%	8.2%	1.3%	1.1%
I. Instrument used in cutting the umbilical cord						
scissors	83.3%	86.9%	58.2%	68.8%	68.4%	65.9%
bamboo	2.4%	-	31.1%	23.0%	27.6%	22.7%
blade	2.4%	1.6%	2.9%	-	-	1.1%
knife	-	-	-	-	3.3%	9.1%
banana frond	-	-	-	-	0.7%	-
DK	11.9%	11.5%	7.8%	8.2%	-	1.1%
J. Percent saying their last birth was difficult	20.2%	26.2%	8.7%	19.7%	16.4%	19.3%
K. Nature of birth's difficulty						
hemorrhage	5	6	4	1	3	6

Table 11. (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
prolonged/dry labor	2	5	1	3	10	6
required operation	1	1	-	-	-	-
breech position of baby	1	3	-	-	1	3
cord wound around neck	2	-	-	-	1	-
pain	-	-	-	6	4	1
combinations	5	1	1	1	5	1
dk/na	1	-	3	-	1	-
L. Percent saying their baby was born healthy	84.5%	93.4%	99.0%	90.5%	96.1%	92.0%
M. Reason for saying the baby is not healthy						
small	5	3	1	-	4	3
weak	2	1	-	-	2	2
underweight	3	-	-	2	-	-
has defect	-	-	-	1	-	-
combinations	1	-	-	-	-	-
dk	2	-	-	-	-	-
N. Special self-care practice of R after delivery						
eat nutritious food	24.7%	10.0%	78.6%	77.0%	55.8%	36.9%
take a bath with herbals	86.4%	96.7%	95.1%	96.7%	17.7%	100.0%
do light chores only	34.6%	43.3%	60.2%	31.1%	22.4%	14.3%
"hilot"	28.4%	16.7%	-	-	8.2%	11.9%
others	8.6%	3.3%	2.9%	-	2.7%	7.1%

Based also on their last birth, most mothers report that their deliveries were normal, although some did undergo difficult birthing. This incidence ranges from 9% to 20% in the Visayas, 16% to 19% in Mindanao, and a higher 20% to 26% in Luzon. Mothers characterized their birth difficulties as involving prolonged/dry labor, postpartum hemorrhages, and other complications.

Because pregnancies and deliveries are seen as generally normal, most mothers are also of the opinion that their last baby was born healthy. The few who thought otherwise felt that their babies were either too weak, small or underweight at birth, conditions that are similarly traceable to the poor health and nutrition of some mothers.

If nearly all mothers report taking special care of themselves after delivery, this is because the traditional practice of bathing with a mixture of boiled leaves/herbals continues to be a "must" for mothers who have recently delivered. This practice, popularly known as "suob" in Tagalog, is said to prevent "binat" or relapse and to help mothers recover faster after delivery. Mothers especially in the Visayas and Mindanao also report eating nutritious foods after birth, while still others claim doing lighter chores or engaging "hilots" for after- birth massages. This latter practice is more prevalent among mothers in Luzon.

Since repeated and frequent pregnancies take a toll on women's health and on babies' as well, maternal and child health programs usually include the provision of family planning services. Several questions on these were therefore also included in the survey interview schedule.

The findings reveal that while the majority of mothers (44% to 79%) no longer wish to have additional children, they have not taken any measure to control or regulate their births (see Table 12). Over 50% of all mothers in the regions, for example have never tried using any form of family planning, while the proportions employing some means of birth control at present comprise a low 20% to 22% in Luzon, 12% to 18% in Mindanao and an even lower 10% to 14% in the Visayas. These figures fall below the estimated 33% family planning user rate for the country as a whole.

The high rate of non-adoption of contraceptives by mothers does not seem to owe to strong objections to birth control. Only 3% to 9% of the never-users express strong objection to family planning because they do not believe in this or because family planning goes against their religious convictions. Another 2% to 11% on the other hand, have not used any form of family planning since they feel they have no need for this, e.g., they are already old, their husband is away, or they have been able to space their children effectively.

It appears that the more important reasons mitigating against the wider use of family planning are women's fears and apprehensions of the side effects of family planning methods (17% to 62%); the objections of their husbands to birth control (5% to 44%); and the desire of younger women to have additional children (6% to 23%). The non-availability of family planning services in the area, and perceptions that family planning methods are not effective or are difficult to follow are some of the other remaining but less frequently mentioned reasons for mothers' non- use of contraception.

Similar patterns showing the saliency of "fears of side effects" and "husband's disapproval" emerge from the reasons given by mothers who have tried some form of family planning in the past

Table 12. Related data on family planning practices by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Total number of additional children R would like to have						
no more	72.6%	44.3%	79.1%	69.8%	77.0%	79.5%
1 more child	9.5%	19.7%	7.6%	14.3%	13.8%	15.9%
2 more children	11.9%	21.3%	3.8%	12.7%	4.6%	4.5%
3	1.2%	3.3%	1.9%	3.2%	2.0%	-
4 or more children	-	-	1.9%	-	-	-
dk	4.8%	11.5%	5.7%	-	2.6%	-
B. Percent of never-users, ever-users and current users of FP						
never used FP	53.6%	55.7%	65.7%	61.9%	53.3%	55.7%
ever used FP	46.4%	44.3%	34.3%	38.1%	46.7%	44.3%
currently using FP	20.4%	21.8%	10.1%	13.9%	18.1%	12.1%
C. Reason why R or spouse never used FP						
afraid of side effects	39.4%	28.0%	17.3%	32.2%	56.4%	54.7%
wants more children	6.1%	24.0%	13.5%	22.6%	12.7%	18.9%
husband disapproves	27.3%	20.0%	44.2%	25.8%	5.4%	5.7%
FP is not available	3.0%	4.0%	9.6%	6.4%	5.4%	1.9%
able to space effectively	3.0%	8.0%	7.7%	3.2%	1.8%	1.9%
old already	-	-	1.9%	-	-	-
husband is out of town	3.0%	4.0%	1.9%	3.2%	-	-
method failure	-	-	-	3.2%	5.4%	-
religious reasons	-	-	1.9%	-	1.8%	-
does not want	3.0%	12.0%	1.9%	3.2%	7.3%	7.5%
contraindicated	15.2%	-	-	-	5.4%	3.8%
can't follow	-	-	-	-	1.8%	5.7%
D. Reason why R or spouse stopped using FP						
experienced side effects	18.2%	-	52.4%	22.2%	39.4%	50.0%
wants more children	9.1%	-	19.1%	44.4%	6.1%	-
husband disapproves	-	33.3%	4.8%	33.3%	-	-
FP is not available	-	16.7%	4.8%	-	-	-
able to space effectively	-	-	4.8%	-	-	-
old already	27.3%	-	9.5%	-	21.2%	10.0%
husband is out of town	9.1%	-	-	-	9.1%	-

Table 12. (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
method failure	36.4%	50.0%	-	-	21.2%	40.0%
does not want	-	-	-	-	3.0%	-
can't follow	-	-	4.8%	-	-	-
E. FP methods R or spouse is currently using						
rhythm	29.7%	17.2%	45.2%	34.8%	66.1%	20.8%
pills	32.4%	41.4%	3.2%	4.3%	15.2%	33.3%
IUD	2.7%	-	25.8%	8.7%	5.1%	29.2%
condom	2.7%	-	-	-	1.7%	-
withdrawal	16.2%	13.8%	6.4%	4.3%	8.5%	4.2%
ligation/vasectomy	24.3%	27.6%	22.6%	47.8%	13.6%	12.5%
injectable	-	-	3.2%	-	1.7%	-
F. _____ mothers would avail of FP if made available in the community						
most	29.8%	11.5%	7.0%	17.5%	11.2%	11.4%
many	57.1%	62.3%	69.0%	69.8%	40.8%	29.5%
only a few	10.7%	16.4%	24.0%	12.7%	25.7%	25.0%
none	2.4%	4.9%	-	-	21:7%	29.5%
dk	-	4.9%	-	-	0.7%	4.5%

but who have now stopped using this. In addition however, mothers also cite the failure of the birth control method they had earlier adopted (21% to 50%) as another reason why they have stopped the practice.

The latter reason, which accounts for a considerable number of family planning drop-outs, is related to the mothers' choices of contraceptive methods. Table 12 shows that among ever- and current-family planning users in the survey, over a third had/have adopted rhythm or withdrawal, both of which are associated with high contraceptive failure rates. In the past, many more women appear to have also used the pills, the IUD and the condom, but based on the data obtained from current users, use of these more effective methods has now dropped significantly. At present, the survey results indicate that mothers' preferences may be shifting towards permanent, effective and safer birth control forms as ligation and vasectomy. These methods are among the leading methods that are currently in use in Luzon and the Visayas, but not in Mindanao where rhythm, pills and the IUD continue to be the more popular forms of birth control.

Finally, when asked whether mothers would avail of family planning services if these were made more accessible in their communities, the majority of mothers (over 75%) say many or most mothers in their areas would do so, except again in Mindanao where closer to 50% said "only a few" or "none" would avail of these services. The responses suggest that mothers continue to see a need for family planning but the task of meeting their needs may require services other than simply dispensing contraceptives. Based on the reasons given by non-users and family planning drop-outs, local family planning services should include a thorough informational support so that mothers can have a better appreciation of the benefits and risks of each form of family planning method vis-a-vis the risks of frequent pregnancies and deliveries. It is also clear that mothers need some follow-up support to help them overcome their fears of contraceptive methods and to assure them of medical attention when they have family planning-related complaints.

The survey findings offer still other suggestions for addressing women's family planning needs and hence, for improving maternal health. Since an increasing number of couples are opting for more permanent ligations and vasectomies, local health workers and practitioners can explore ways of accessing such services for their communities. They can also step up efforts to reduce the incidence of infant and child deaths that, in turn, can reduce "replacement pregnancies" or those pregnancies that mothers have in order to compensate for earlier child deaths.

In the area of maternal health therefore, we note that mothers continue to depend largely on the services of doctors, "hilots" and midwives. Although primary health care workers as the CHWs and BHWs have been approached by some women for prenatal and family planning advice and to assist in deliveries, they still have to make an impact in assisting mothers to go through healthy pregnancies and safe deliveries and in gaining control over their bodies. The findings reveal there are opportunities for them to do so by expanding their information, referral, and support activities to encourage women to seek and heed prenatal and postnatal advice and family planning services. Any additional training that primary health workers can have in child delivery will also be useful in ensuring the safe and sanitary deliveries of mothers in their communities.

Infant Feeding and Child Care

Like the health of mothers, measures on the health of children are similarly used as indicators of the well-being of households and communities. The reason for this is because children, and particularly infants (under 1 year old), are a high-risk group who are the most vulnerable to communicable and other forms of diseases. The incidence of morbidity and mortality among children, therefore, is generally regarded as indicative of the adequacy of nutrition and incomes among households, the sanitation and health services obtaining in communities, and the overall socioeconomic development of given localities. The well-being of children also has other long-term implications since the health status of adult family members is conditioned in part by their health conditions when they were children.

Areas for improving the health of children has been noted in earlier sections and include the need for reducing the still considerable incidence of illnesses and deaths among children. In addition to improving the nutrition of mothers during pregnancies, the incidence of child morbidity and mortality could further be reduced if more mothers consult health practitioners for the care of their babies after birth. Currently, mothers in the survey areas tend to seek postnatal advice only when their babies are ill or at best, only a few times (no more than 3 times) during their babies' first year of life. The only exception are mothers in the Visayas, who bring their babies for more frequent or regular check-ups (see Table 13).

Mothers who bring their babies for health check-ups are expectedly advised to give their babies nutritious food and/or vitamins. In Mindanao and the Visayas, mothers have also been advised to have their babies immunized (36% to 43% and 18% to 22% respectively). The child immunization campaign does not seem to have taken off as well in the Luzon study communities where mothers who have been asked to have their babies immunized comprise a minimal 3%.

In treating their babies' ailments, mothers are asked by health practitioners to use either traditional remedies (largely, herbals) or modern medicines. There are regional variations in these: there are more mothers in the Visayas who have been asked to use traditional remedies in treating their children since mothers in the region prefer consulting primary health care workers (both CHWs and BHWs) for the care of their babies. In Luzon and Mindanao, on the other hand, mothers generally go to professionally trained health workers (e.g., doctors, nurses and midwives) for postnatal consultations. Consequently, more of them resort to modern medicines than to traditional remedies in treating their babies' ailments.

Whereas mothers seldom follow the health advice given them during their pregnancies, they are more religious in complying with those given for their children. Despite their poor incomes, most do their best to provide their infants with vitamins and nutritious foods nutritious foods and to follow the other prescribed treatments for their babies. Across the 3 regions, however, mothers in Luzon report more difficulties complying with baby-care advice because they cannot afford to buy the prescribed vitamins and nutritional supplements for children.

Table 13. Related data on infant feeding and child care practices by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Mode of infant feeding						
Percent who breastfed	62.6%	76.7%	68.0%	74.1%	76.3%	74.7%
Percent who bottlefed	9.6%	3.3%	4.8%	8.6%	11.2%	8.0%
Percent who mixedfed	27.7%	20.0%	27.2%	17.2%	12.5%	17.2%
B. Type of formula used for bottlefeeding						
infant formula	54.5%	88.9%	54.5%	66.7%	46.2%	58.8%
powdered milk	13.6%	-	30.3%	-	15.4%	23.5%
condensed milk	4.5%	-	12.1%	26.7%	11.5%	5.9%
evaporated milk	27.3%	11.1%	3.0%	-	3.8%	5.9%
any combination	-	-	-	6.7%	23.1%	5.9%
C. Duration of breastfeeding among mothers who ever breastfed						
up to 3 months	12.2%	6.7%	14.7%	22.2%	12.7%	13.9%
4 - 6 months	6.8%	10.0%	13.7%	3.7%	9.0%	12.7%
7 - 9 months	10.8%	11.7%	12.6%	9.3%	14.9%	12.7%
10 - 12 months	39.2%	30.0%	27.4%	14.8%	34.3%	25.3%
over 12 months	31.1%	41.7%	31.6%	50.0%	29.1%	35.4%
Mean	12.2	13.1	13.3	15.0	11.9	12.1
D. Number of months after birth R gave food other than milk						
1 - 3 months	10.4%	-	16.8%	8.5%	15.4%	13.8%
4 - 6	68.8%	86.0%	66.3%	72.3%	56.1%	60.0%
7 - 9	14.3%	8.8%	16.8%	12.8%	19.5%	23.1%
10 - 12	6.5%	5.3%	-	6.4%	8.9%	3.1%
E. Type of food R gave her last baby						
rice	17.3%	23.2%	21.3%	6.2%	23.6%	29.2%
cerelac	14.7%	14.3%	2.3%	12.5%	2.4%	4.6%
rice and cerelac	-	1.8%	2.3%	6.2%	10.6%	1.5%
fruit and vegetable	12.0%	7.1%	15.7%	14.6%	37.4%	43.1%
rice and fish	9.3%	19.6%	6.7%	2.1%	10.6%	6.2%
rice, cerelac and fruit	1.3%	5.4%	37.1%	43.8%	5.7%	7.7%
rice, fruit and egg	45.3%	28.6%	14.6%	14.6%	9.8%	7.7%

Table 13. (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
F. Percent of mothers who had sought post-natal care	36.9%	21.3%	77.7%	80.3%	34.9%	34.1%
G. Frequency of post-natal consultation (N= only among mothers consulting for postnatal care)						
monthly	26.7%	46.2%	57.5%	81.6%	6.0%	10.7%
8 times	-	-	2.5%	-	-	3.6%
6 - 7 times	6.7%	-	5.0%	-	4.0%	-
4 - 5 times	13.3%	-	8.8%	2.0%	20.0%	32.1%
2 - 3 times	16.7%	15.4%	15.0%	10.2%	42.0%	42.9%
once only	20.0%	30.8%	8.8%	2.0%	24.0%	10.7%
everytime the child is ill	16.7%	7.7%	2.5%	4.1%	4.0%	-
H. Nature of post-natal advice						
immunization	3.2%	-	22.5%	18.4%	36.5%	43.3%
use traditional remedies	9.7%	7.7%	28.8%	34.7%	15.4%	10.0%
use modern medicine	9.7%	46.2%	23.8%	4.1%	23.1%	26.7%
give vitamins	38.7%	30.8%	27.5%	22.4%	30.8%	33.3%
give nutritious food	25.8%	15.4%	23.8%	26.5%	17.3%	40.0%
proper hygiene	16.1%	-	16.2%	18.4%	11.5%	13.3%
give solid food	16.1%	7.7%	1.2%	4.1%	1.9%	6.7%
regular check-up	6.4%	15.4%	-	-	30.8%	6.7%
I. Incidence following advice						
Percent following 1st advice	48.3%	61.5%	97.3%	93.6%	98.1%	93.3%
Percent following 2nd advice	71.4%	100.0%	96.6%	87.5%	96.3%	94.1%
Percent following 3rd advice	100.0%	100.0%	100.0%	-	100.0%	100.0%

In addition to well-baby consultations, practices surrounding the feeding of infants/babies also influence the health of children. Various groups have thus advocated the promotion of breastfeeding among mothers especially in the Third World, in view of the limited incomes of families and the beneficial effects of breastfeeding on the health of infants and babies. Breastfeeding affords the young with additional immunity from diseases, as well as some contraceptive protection for mothers in the short term. By delaying new pregnancies, breastfeeding improves the health of mothers and in the process, also the care of infants and babies.

Table 13 indicates a more pronounced decline in the incidence of breastfeeding in the survey communities than in other Philippine localities. Whereas the incidence of breastfeeding nationally is estimated at around 80% to 83%, the prevalence of the practice stands at a lower 63% to 77% in the survey communities. Mothers who breastfeed their infants in the survey areas, however, do so for around 12 to 13 months, which is comparable to the average duration of breastfeeding in the Philippines.

The shift in infant feeding practices in the survey areas has been towards mixed feeding (breast and bottle) rather than to complete bottlefeeding. Most of these mothers now rely on infant formula or powdered milk, although many others give their babies condensed or evaporated milk or some other combinations that cannot adequately substitute for mothers' milk. Even the use of infant formula and powdered milk which are generally considered the better substitutes for mothers' milk, is usually discouraged among low-income households, given the tendency of mothers to dilute this too thinly in order to economize. Mixed feeding and bottlefeeding also entails additional health risks for poor families in view of their lack of sterilization knowledge and facilities.

Most mothers say they begin to supplement their babies' milk intake with other foods during the fourth to the sixth month of their baby's life. These supplements commonly consist of rice, or of rice mixed with fruit, vegetables or eggs. Not a few also report giving their babies "Cerelac", a commercial baby food preparation consisting largely of rice which families themselves can produce and/or process into baby food. Experiences elsewhere in the Third World show that the production and processing of grains, nuts and other produce into infant food by local mothers' cooperatives can do much to reduce malnutrition among children. In addition therefore, to encouraging mothers to breastfeed, primary health care workers should likewise look into the possibilities of integrating local food production activities with the preparation of food supplements for infants and babies.

The survey results further indicate badly needed support in another area of children's health, which is the immunization of children against eradicable diseases. Table 14 reveals substantial numbers of young children under 7 years old in the survey areas who have not been immunized for various ailments. The proportions of mothers who say that none of their children have received a single dose of immunization are highest for measles (27% to 44%) and DPT (8% to 56%), followed next by polio (8% to 28%) and BCG (3% to 22%). Except for BCG, where the majority of mothers (53% to 75%) have their children immunized for the complete series of the vaccine, most mothers report only the partial immunization of children against DPT, polio and measles. As a result, the incidence of households where all young children under 7 years old have been completely immunized for BCG, DPT, polio and measles stands only at 41% to 44% in Mindanao, and a lower 33% to 36% in the Visayas. In Luzon, complete immunization coverage of children for all diseases is much lower

Table 14 (cont'd)

Table 14. Related data on children's immunization by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Number of children 7 years old or younger						
with no young children	21.4%	16.4%	8.6%	3.2%	12.5%	8.0%
with 1 child	32.1%	34.4%	21.9%	31.7%	26.3%	31.8%
with 2 children	22.6%	18.0%	40.0%	36.5%	27.0%	27.3%
with 3	4.8%	6.6%	9.5%	6.3%	10.5%	13.6%
B. Incidence of BCG immunization among R's children						
none have been immunized	11.8%	3.1%	7.3%	16.4%	18.8%	22.2%
some have been, others not	25.5%	43.8%	17.7%	9.8%	24.1%	17.3%
all have been immunized	62.7%	53.1%	75.0%	73.8%	57.1%	60.5%
C. Incidence of DPT immunization among R's children						
none have been immunized	29.4%	56.2%	8.3%	26.2%	24.8%	24.7%
some none, some partial	19.6%	18.8%	4.2%	-	3.0%	3.7%
all partially immunized	29.4%	18.8%	6.2%	1.6%	6.0%	6.2%
some partial, some complete	5.9%	-	12.5%	6.6%	6.8%	3.7%
some none, some complete	-	6.2%	15.6%	8.2%	15.8%	16.0%
all completely immunized	15.7%	-	53.1%	57.4%	43.6%	45.7%
D. Incidence of anti-polio immunization among R's children						
none have been immunized	27.4%	46.9%	8.3%	27.9%	24.1%	25.9%
some none, some partial	25.5%	18.8%	4.2%	-	3.8%	3.7%
all partially immunized	25.5%	28.1%	6.2%	1.6%	5.3%	4.9%
some partial, some complete	5.9%	-	5.2%	4.9%	5.3%	2.5%
some none, some complete	2.0%	3.1%	21.9%	8.2%	18.0%	17.3%
all completely immunized	13.7%	3.1%	54.2%	57.4%	43.6%	45.7%
E. Incidence of anti-measles immunization among R's children						
none have been immunized	27.4%	43.8%	29.2%	34.4%	37.6%	33.3%
some have been, others not	23.5%	25.0%	30.2%	11.5%	23.3%	28.4%
all have been immunized	49.0%	31.2%	40.6%	54.1%	39.1%	38.3%
F. Incidence of complete Immunization among R's children						
all of R's children have						

Table 14. (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
been immunized for BCG, DPT, polio and measles	13.7 %	-	40.6 %	44.3 %	33.1 %	35.8%
none of R's children have received any form of immunization		22.7 %	37.2 %	30.2 %	16.4 %	13.5 % 21.

at 14% among served households and none among the unserved households. The above figures suggest that the survey areas most likely lag behind other Philippine rural communities in terms of child immunization coverage, given the stepped-up nationwide efforts towards the full immunization of children.

Medicinal Plants

Data on the availability of medicinal plants near or around the respondents' houses reveal systematic differences between served and unserved households, although there are also other observed regional differences which probably owe to the "indigeneity" of medicinal plants across the regions (see Table 15). It appears that the CHWs in the survey communities have made some headway in encouraging the planting and use of medicinal plants. Hence, regardless of region, a consistently higher proportion of the CHW-served households have these plants readily available within their premises than the unserved households. Of the various medicinal plants, "herba maris" may be the least cultivated, and thus, also the least available in the 3 regions. Ginger or "luya" is not widely grown in Luzon but is prevalently so in Mindanao. In the Visayas, the medicinal plants that are scarce are "lagundi" and "damong maria". The other medicinal plants -- sampalok, kalamansi, abokado, bayabas, kaymito, banaba, oregano, herba buena, and sambong are relatively more prevalent, with generally over 40% of households saying these are available near their homes or their backyards.

Although herbals are increasingly being prescribed for treating many of the common ailments and other illnesses that afflict households (e.g., cough, diarrhea, fever, kidney problems, high blood pressure etc.), some constraints remain in promoting their wider acceptance and use. For one, even as households come to recognize the usefulness of herbals, supply remains a problem since medicinal plants are still not widely grown in the program communities. Moreover, as will be discussed in the next section, some respondents have not complied with herbal prescriptions either

Table 15. Data on the availability of medicinal plants by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Percent of HHs saying _____ is available in their own or neighbor's yard						
sampalok	76.2%	72.1%	26.7%	19.1%	40.1%	39.8%
luya	25.0%	13.1%	21.9%	20.6%	63.2%	53.4%
kalamansi	39.3%	41.0%	61.9%	66.7%	71.1%	65.9%
abokado	71.4%	59.0%	63.8%	58.7%	70.4%	50.0%
bayabas	95.2%	95.1%	77.1%	71.4%	91.4%	90.9%
kaymito	85.7%	80.3%	63.8%	46.0%	74.3%	59.1%
banaba	36.9%	26.2%	40.0%	41.3%	30.3%	23.9%
oregano	78.6%	45.9%	48.6%	34.9%	46.7%	27.3%
herba buena	44.1%	24.6%	46.7%	42.9%	66.4%	65.9%
herba maris	25.0%	18.0%	28.6%	25.4%	30.9%	26.1%
sambong	52.4%	42.6%	49.5%	34.9%	55.9%	48.9%
lagundi	64.3%	47.5%	7.6%	4.8%	22.4%	20.4%
damong maria	52.4%	41.0%	11.4%	11.1%	44.7%	44.3%

because they find these difficult to follow, or because they say they "do not trust herbals". To a certain extent these reasons are related to the fact that in many areas, herbal medicines still do not come in convenient forms and preparations (e.g., tablets, capsules or syrup). Other strategies, therefore, must be found to ease these constraints in the acceptance of herbal medicines.

It would seem that linking the program communities with some of the centers that now produce herbal preparations (i.e., the RMP in Negros) can help in propagating the use of herbal medicines. It should be noted that a population exposed to notions of Western medicine and already used to obtaining medicines in the "botica" (drugstore), a return to herbals psychologically suggests a step backward rather than an advance. As in the case of breastfeeding, there is the need to counter the pull of modern ways and conveniences by showing not only the utility and benefits of traditional and indigenous forms, but by making their use also more convenient. In the case of medicinal plants, their packaging and processing into ready preparations can do much to break natural attitudinal barriers to their acceptance.

V. CHW Services and Relationships with Households

CHW Services

CHWs render services to local households in a most personal manner by visiting them in their homes. The large majority of served households in all regions (90% in Luzon and close to 80% in Visayas and Mindanao) report having been visited by the CHW, and usually within the last 3 months prior to the survey (Table 16). CHWs commonly visit households to cure a sick family member, although in other instances, they also visit households to render other health services (weigh children, give other advice), inform families about health clinics and meetings, or to simply maintain their contacts/linkages with households.

A high 72% to 81% of the served households also say they themselves have gone to visit and consult the CHW, with most similarly doing so in the last 3 months. Consistent with earlier findings showing CHWs are attending to increasing cases of minor illnesses, most respondents say they last visited the CHW to consult her regarding a family member's illness. A few others visited the CHW for other purposes, such as to ask her for referrals, herbal medicines, or for prenatal and nutritional advice.

Of the community activities organized by CHWs, households in the Visayas have attended mostly the health clinics organized by the CHW (69%). In Mindanao and Luzon, on the other hand, there are more households that have participated in the preparation of herbals conducted by CHWs. Still some other households report attending sanitation-related seminars or meetings called by the CHW. In all regions, however, respondents report much lower attendance (3% to 8%) of CHW-iniatiated mothers' classes and child care and nutrition sessions. While this may express a low preference for

Table 16. Nature of HH's contact with CHWs among served households by region.

	LUZON	VISAYAS	MINDANAO
A. Percent of HHs saying they have been visited by the CHW	90.4%	79.1%	78.3%
B. Number of months since CHW's last visit to HH			
1 - 3 months	76.9%	75.9%	56.1%
4 - 6	15.4%	6.3%	6.5%
7 - 9	3.8%	2.5%	3.7%
10 - 12	1.9%	6.3%	22.4%
over a year ago	1.9%	8.9%	11.2%
C. Nature of CHW's visit to the HH			
visit children/family	19.2%	44.9%	25.2%
cure sick HH member	41.1%	21.8%	48.7%
inform HH re clinic/ meeting	1.4%	23.1%	6.7%
give health-related advices	12.3%	3.8%	10.1%
weigh children	23.3%	3.8%	0.8%
attend to pre-natal/ delivery	2.7%	2.6%	8.4%
D. Percent of HHs saying they have gone to CHW for consultation	80.7%	79.1%	72.4%
E. Number of months since HH last consulted the CHW			
1 - 3 months	75.0%	69.2%	51.0%
4 - 6	10.4%	10.2%	10.8%
7 - 9	4.2%	2.6%	5.9%
10 - 12	10.4%	11.5%	21.6%
over a year ago	-	6.4%	10.8%
F. Purpose of HH's last consultation with the CHW			
for illness	87.9%	71.8%	72.5%
for referral	-	5.1%	0.9%

Table 16 (cont'd)

	LUZON	VISAYAS	MINDANAO
for herbal medicine	12.1%	14.1%	25.7%
for pre-natal advice	-	7.7%	0.9%
for nutritional advice	-	1.3%	-
G. Type of activities organized by the CHW and attended by HH			
health-related meetings/ talks/seminars	29.7%	16.1%	29.6%
clinics	29.7%	69.1%	-
preparation of herbals	32.4%	12.3%	66.2%
mothers'classes/child care/nutrition sessions	8.1%	2.5%	4.2%
H. Health advices/practices taught by the CHW			
none	9.6%	7.7%	10.6%
sanitation	9.6%	57.7%	38.4%
nutrition	6.0%	53.8%	31.1%
disease prevention	2.4%	16.3%	0.7%
care of children	1.2%	10.6%	5.3%
immunization	-	5.8%	-
use of herbal medicine	86.7%	42.3%	62.9%
others	3.6%	12.5%	9.9%
I. Percent of HHs who have not been able to follow all or some of CHW's advices	13.2%	13.5%	13.2%
J. Reasons why HH was not able to follow the CHW's advice			
no money	18.2%	28.6%	35.0%
herbals are not available	27.3%	14.3%	10.0%
don't trust herbals	18.2%	14.3%	10.0%
no space to plant vegetables	9.1%	14.3%	-
no space for waste disposal	-	-	10.0%
too busy to follow advice	27.3%	42.9%	40.0%
difficult to follow	-	-	15.0%
K. Percent of HHs saying they			

Table 16 (cont'd)

	LUZON	VISAYAS	MINDANAO
have received health-related reading materials from the CHW	20.5%	9.5%	25.0%
L. Reading materials considered useful by the HH			
preparation of herbal medicine	88.2%	42.9%	62.2%
"Where there's no Doctor"	5.9%	14.3%	8.1%
pre-natal materials	-	14.3%	-
FP materials	-	14.3%	-
nutrition materials	-	14.3%	29.7%
first aid materials	5.9%	-	-

mothers' classes and child care and nutrition sessions. While this may express a low preference for mothers'/child care/nutrition classes among the households, it could also be that CHWs organize or conduct fewer of these activities in their areas than other kinds of health seminars.

The data further indicate that the present thrust of CHW services and activities is heavily tilted towards the treatment of common illnesses with herbal medicines. When asked what they were taught by the CHW, most respondents recall learning about the use of herbals. This is overwhelmingly so in Luzon where 87% of respondents say they were taught about herbals, whereas fewer than 10% recall learning about other things as sanitation, nutrition, child care and immunization, and other measures of disease prevention. Similar patterns obtain in Mindanao although not to such an extreme extent. About a third of respondents in the region each recall learning about sanitation and nutrition, while close to two-thirds learned about herbals. The picture is somewhat more balanced in the Visayas where slightly over 50% recall learning about sanitation and nutrition, and 42% about herbals. Since primary health care is designed to promote as much, if not more, of preventive than of curative medicine, the foregoing findings should alert community-based health programs on the need for striking a balance in their services and in the training of CHWs. Compared to the advice given by physicians which families are unable to follow because these entail buying expensive medicines, families generally have few difficulties following the advice of CHWs. The reasons given by the few who are unable to follow these, however, are related to the earlier mentioned supply and convenience problems with herbals. Respondents variously claim they are too busy to follow the CHW's advice, these are too difficult to follow, herbals are not available in their areas, or they do not trust herbals.

It does not look like CHWs have maximized the use of health reading materials since the greater number of families do not recall receiving such materials from CHWs. Those who did comprise 25% in Mindanao, 20% in Luzon, and a low 9% in the Visayas. Again, the reading materials shared by the CHW with households are largely on herbals, which respondents say they found most useful, in part because they probably did not receive any other kind of health reading material from CHWs.

Table 17. Household support and rating of CHW among served households by region.

	LUZON	VISAYAS	MINDANAO
A. Manner of selecting CHW in the community			
elections	100.0%	92.5%	79.4%
raffle	-	5.0%	-
appointment	-	2.5%	20.6%
B. Percent of HHs saying they participated in the selection of the CHW	7.2%	40.0%	28.3%
C. Nature of community support given the CHW			
none	11.1%	77.4%	40.8%
cash/kind donations/ gifts for CHW	47.2%	6.9%	58.4%
lends time/labor assistance to CHW - help inform others of meetings, help build clinics/help in clinic	9.7%	2.0%	-
attends activities organized by the CHW	6.9%	3.9%	-
lend their cooperation and moral support to the CHW	40.3%	9.8%	2.1%
D. Nature of own HH's support given the CHW			
none	20.5%	33.3%	37.7%
cash/kind donations/ gifts for CHW	55.4%	42.9%	59.0%
lends time/labor assistance to CHW - help inform others of meetings, help build clinics/help in clinic	3.6%	21.0%	2.7%
attends activities organized by the CHW	3.6%	6.7%	1.4%
lend their cooperation and moral support to the CHW	24.1%	13.3%	2.7%
E. R's opinion of the CHW's services			

Table 17. (cont'd)

	LUZON	VISAYAS	MINDANAO
very useful	39.0%	32.0%	40.8%
useful	61.0%	59.2%	58.6%
not too useful	-	8.7%	0.6%
F. R's rating on the industry and work habits of the CHW			
very industrious	21.1%	10.8%	32.2%
industrious	78.9	85.3%	65.1%
not too industrious	-	3.9%	2.6%
G. R's rating of the CHW's dealings/relations with people of the community			
very satisfactory	15.6%	1.0%	29.8%
satisfactory	81.8%	99.0%	69.5%
not satisfactory	2.6%	-	0.7%
H. R's rating of CBHP in the community			
very beneficial	44.6%	35.3%	39.5%
beneficial	55.4%	56.9%	59.9%
not too beneficial	-	7.8%	0.6%

Relationships Between Households and CHWS

Since the health programs in the survey areas are promoted as community-based programs, findings showing that only a minority of respondents participated in the selection of their local CHWs are somewhat disturbing. In the Visayas, only 40% of households report participating in the selection of their CHW, whereas in Mindanao and Luzon, the proportions are even lower at 28% and 7% respectively (see Table 17). The data are not too clear on the reasons behind this low level of participation. It is possible however, that some of the currently served households were still not members of their local organizations when their CHWs were selected, or they probably were away at the time their CHWs were chosen. Because the survey respondents are mothers/women, it may also be the case that they were excluded in the selection of the CHW, particularly if decision- making processes in local organizations rest largely on men. Among those participating in the selection of CHWs however, the majority report this was done through elections. Only a few respondents relate their CHWs were chosen through raffle or were appointed (in consultation with them) by the parish priest or their local organization.

Many of the families served by CHWs--ranging from 43% in the Visayas to 55% in Luzon and 59% in Mindanao--directly contribute to the maintenance of their CHWs by giving them donations and gifts in cash or kind. Others assist the CHWs in other ways like helping them organize meetings, build clinics or manage these. Still others say they always lend their cooperation and moral support to the CHWs.

Families in the Visayas feel, however, that other than the support given by (served) families like themselves, CHWs do not get as much support from their communities at large. This is in contrast to the situation in Luzon where respondents perceive their communities to be much more active in supporting the CHWs. Their local organizations usually contribute money or give other kinds of donations to the CHWs and lend them their full support and cooperation. Mindanao is somewhat in between: though 58% of families say their communities help maintain the CHWs with cash or kind donations, as many as 41% say the CHWs receive no assistance whatsoever from their communities.

The household-clientele of CHWs are apparently pleased and happy over the performance of their CHWs. Regardless of region, families consider the CHW's services as either useful or very useful. With very few exceptions, all CHWs are perceived as hardworking, if not very hard working.In addition, CHWs are likewise rated as maintaining satisfactory or very satisfactory relationships with people in the communities. Given the very minimal dissatisfaction with the CHWs who are the front line workers of community-based health programs, it is also not surprising that households should view their local health program positively. The great majority of households feel that the CBHP program has been beneficial or very beneficial to their communities.

Table 18. Measures needed to improve the health status of families in the community and most pressing problems of the community by served and unserved households and by region.

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
A. Measure considered most important by the HH to improve the health status of families in the community						
none	1.2%	3.4%	3.8%	1.6%	2.0%	4.8%
sanitation-related measures (proper drainage, pigs kept penned and clean, provision of toilets, sanitary garbage disposal, etc.)	36.1%	24.1%	29.5%	28.6%	37.7%	36.9%
provision of safe water	2.4%	3.4%	2.9%	1.6%	6.6%	6.0%
provision of additional clinics/doctors and other medical personnel	60.2%	55.2%	26.7%	34.9%	27.2%	27.3%
increase support for CBHP program and CHW services	12.0%	6.9%	18.1%	4.8%	28.5%	11.9%
additional health education (on nutrition, disease prevention, care of children)	37.3%	39.6%	26.7%	39.7%	49.7%	58.4%
improve economic conditions	3.6%	3.4%	2.9%	3.2%	4.6%	4.8%
B. Most pressing problems of the community						
none	4.8%	3.3%	3.8%	1.6%	2.7%	3.5%
lack of food	21.7%	21.3%	9.5%	1.6%	14.0%	17.5%
lack of employment/ livelihood	53.0%	54.1%	36.2%	20.6%	41.4%	31.4%
lack of capital/land/ other resources	26.5%	32.8%	1.9%	-	2.0%	3.5%
lack of water facilities	10.8%	3.3%	6.7%	20.6%	36.6%	44.2%
lack of sanitation (no drainage, no toilets)	10.8%	1.6%	32.4%	42.9%	5.3%	8.1%
lack of other Infrastructures (roads, electricity, transportation, irrigation, streetlights,						

Table 18. (cont'd)

	LUZON		VISAYAS		MINDANAO	
	served	unserved	served	unserved	served	unserved
school buildings, etc.)	21.7%	39.3%	10.5%	14.2%	42.0%	37.2%
lack of other social services (education, health, day care, chapel/church, recreation, etc.)	12.0%	4.9%	6.7%	3.2%	20.1%	10.4%
social problems (theft, gambling, drugs, fights, no unity, crimes, etc.)	13.2%	9.8%	16.2%	14.3%	13.3%	10.5%
high prices	27.7%	34.4%	-	-	14.7%	7.0 %

Community Problems and Health Needs

Data on the households' perceptions of the most pressing problems of their communities confirm earlier findings on the poor conditions obtaining in the survey communities and the economic difficulties of families (see Table 18). Most families see the problems of their communities as largely economic, e.g., the lack of employment, lack of land, lack of capital, lack of food, and the high prices of basic commodities. Perceptions that communities suffer from a severe lack of basic facilities (water, toilets, drainage) and other infrastructures (roads, electricity, irrigation) are likewise prevalent. But in general, fewer respondents consider the lack of social services (education, health, etc.) and the incidence of criminality and social problems in their areas as urgent community problems.

The acuteness of community problems differs by region. The Luzon program communities are probably the worst off economically. Not only does the majority of respondents complain about the lack of employment and livelihood opportunities (53% to 54%), but substantial proportions also express concern over the scarcity of land and capital (27% to 33%) and of food (22%) in their communities. Compared to their counterparts in the Visayas and Mindanao, more Luzon households (28% to 34%) also see the high and increasing prices of food as a major problem in their localities. Because they are more favored in terms of certain infrastructures as water and electricity however, the lack of these do not emerge as important problems in Luzon, although many consider the continuing lack of roads and irrigation facilities as major problems in their areas.

The scarcity of employment and livelihood opportunities also figures as a leading community problem in the Visayas and Mindanao, but this is not compounded by the lack of land, capital and food nor of perceptions of increasing prices in the 2 regions. Other than the scarcity of employment, respondents in the Visayas see the lack of local sanitation facilities (toilets/drainage) as pressing community needs (32% to 43%). In Mindanao, respondents feel more acutely the lack of infrastructures (37% to 42%), particularly of roads and electricity and the shortage of water (37% to 44%), as constraining the development of their communities.

While respondents are deeply aware of the economic problems of their communities, most respondents point to the provision of certain basic services as the immediate measures that can improve their community's health, rather than the solution of their wide- ranging and complex economic problems. In all 3 regions, the three most important measures suggested by households to improve the health of their areas are (1) the conduct of sanitation- related measures as proper drainage, keeping pigs in clean pens, and sanitary toilet and garbage disposal systems; (2) the provision of additional clinics, doctors and other health personnel; and (3) the provision of additional health education on nutrition, disease prevention and the care of children.

The importance of these measures, however, does not necessarily follow the same order in the three regions. The Luzon families whose homes are farther away from health facilities (see Section II earlier), feel more acutely the need for additional health facilities and personnel (55% to 60%); whereas in Mindanao, households would most want to have additional health education on nutrition, disease prevention and child care (50% to 58%). In the Visayas, roughly an equal number of between a fourth to a third of respondents consider sanitation measures, the provision of additional health facilities/ personnel, and the provision of additional health education as the important measures to improve the health conditions of their communities.

Of the measures suggested by respondents, primary health care workers should, in theory, be in a position to more readily respond to the suggestions for improved sanitation and additional health and nutrition education. To a certain extent, community- based health programs may already be filling in the third identified need for additional health services and personnel through the fielding of CHWs. But given the many remaining health needs and demands of families, it is unrealistic to expect that CHWs can sufficiently respond to these. The data suggest that if the CHWs in the study areas have concentrated their efforts on curative measures rather than on the promotion of preventive medicine, it is because the need to attend to the sick is clearly the more urgent in their communities. Since the incidence of illness remains high in most areas, the task then of simply responding to and treating the sick can overburden the CHWs. Increasing the number of CHWs in certain places therefore, may help ease these burdens and allow CHWS to respond to the call for other measures in the areas of sanitation and health education. Additionally, an equal emphasis on these and other disease prevention measures in the training of CHWs is probably needed to raise their appreciation of preventive health measures and enable them to respond to the identified sanitation- and health education needs of families.

VI. Conclusions and Recommendations

The areas reached by the community-based health programs of the Rural Missionaries of the Philippines, the Community-Based Health Services, and the Council for Primary Health Care consist of poor communities which suffer from different forms of deprivation. The survey findings show households in the areas engage in various unremunerative on-farm and off-farm activities that hardly give them livable wages and incomes. In addition, families in the program areas must endure the absence or inadequacy of basic facilities as roads, electricity, water and irrigation which marginalize economic activites and keep the population isolated from outside contacts. Expectedly, few govern-

ment social and technical or extension services reach the communities, impeding further the development of people and skills and the general progress of communities.

Of the areas covered in the study, the Luzon communities are possibly the most cash-strapped and economically disadvantaged. This is shown not only by the data on household incomes but by the recognition articulated by households themselves of the multitude of economic problems confronting their communities. Because of low agricultural yields, families that depend only on rootcrops and bananas at certain times of the year are not unfamiliar occurrences in the Luzon program areas. Moreover, although the region's incidence and patterns of illnesses and deaths which are readily traced to malnutrition and poor living conditions, are not dissimilar from those noted in the other 2 regions, starvation as a cause of early death is reported only by families in Luzon. Finally, the program communities in the region are least reached by public health services, even as comparatively more households in the areas have benefited from the rural electrification and water development projects of government.

Though similarly suffering from extreme economic pressures, households in the Mindanao program areas seem at least to have the advantage of having more land to grow their food. Consequently, the Mindanao households exhibit relatively more varied diets, though not necessarily more adequate or nutritious. Families in the region also enjoy somewhat greater access to government health services, particularly those of Barangay Health Workers and Rural Health Units. However, the Mindanao program areas are least serviced by basic infrastructures like electricity and water. The abject conditions in the region continue to be reflected in the incidence of malaria which is a leading illness among local households. In addition, it should be noted that the already precarious economic and health conditions of the Mindanao households have not been helped by the continuing insurgency conflict in the region, which has caused serious injuries and even deaths in the program communities.

The Visayas households basically share the same socioeconomic and health problems of families in the other regions, even as they live in somewhat urbanizing places and are less dependent on subsistence agricultural activities. They are, thus, better reached by infrastructural amenities except for water which remains a major problem of many families. Various data on their local incomes and on the incidence and nature of household illnesses in the region show that the Visayas program areas are not markedly better off economically or socially than those in Luzon and Mindanao.

If the task of rebuilding health which has been severely impaired by economic want is already daunting, that of uplifting and improving the health of communities with a continuing poor economic base is doubly formidable. In effect, it is the latter task that CHWs of the RMP, CBHS and CPHP have had to face in the communities to which they were assigned.

Because of the lack of public health facilities and the inappropriateness of some existing ones, CHWs have been providing badly needed services to families in the program communities. Since health work is used as an organizing entry point in many program communities, CHWs have performed organizing tasks in addition to curing the sick and initiating various kinds of health-related activities. These activities include organizing health clinics, promoting the growing and use of herbal medicines, and conducting sanitation campaigns, and nutrition and health education meet-

ings. In view of the continuing high incidence of illness in the program communities, however, CHWs have inadvertently focused their efforts and attention on curing the sick with available medicinal plants to the neglect of other areas of preventive health care. Hence, while the community organizing efforts of CHWs are enabling, their health assistance has been largely reactive--undertaken in response to the frequent occurrence of illness in the program communities rather than directed towards reducing this through measures that can control the spread of diseases.

At this point, the survey findings suggest a reassessment of the role of CHWs towards defining their services and functions more realistically, and conserving their energies and talents for longer-term service to communities. (The accompanying case studies of the CBHP evaluation reveal a high turn-over rate, and not an infrequent incidence of "burn-out" among CHWs.) Community-based health programs, therefore, should perhaps take stock of the numbers of their program areas and CHWs and arrive at a more judicious ratio for the area assignment and/or household coverage of CHWs. Community-based health programs should similarly review their activities and prioritize the kinds of services they wish to bring to communities. Admittedly, the task of determining priorities will be difficult considering the enormity and multitude of the socioeconomic and health problems currently obtaining in the program localities. Nonetheless, given the resource limitations of community-based health programs, there is a need to prioritize program goals and services, and to align these better with implementing strategies and the resources that the programs have at hand.

With regard implementing strategies, the survey results indicate that the programs may be able to focus more on health concerns by not only developing organizational networks but by cultivating working linkages with those groups engaged in delivering community organizing, livelihood, skills training and other forms of assistance to communities. The gains from these activities and those gained from community health activities are mutually reinforcing, but each is time intensive and requires different kinds of specialization or expertise. Linking with other "special service" organizations therefore would allow for a division of labor and free the CHWs to concentrate on addressing the identified health needs of communities.

Still related to implementing strategies, community-based health programs can further lighten the load of CHWs by having a ready directory of nearby or alternative health facilities (RHUs, other government/private health facilities and personnel) to which CHWs can refer their cases or clients. The survey data reveal that there are some of these facilities which local families do not use as frequently. While these facilities may not be as closely or conveniently located, and while professionally-trained and government health personnel cannot match the "personal touch" of CHWs, they nonetheless offer some services that families need. The responsibility for health care must fall on all participants--the families themselves, the CHWs and other health facilities and professionals. Hence, families must be encouraged to seek medical attention when they need to and to use existing health facilities, even as CHWs work to further elevate health consciousness among family members. Other health facilities and personnel who are obligated to provide health services must be pressured further to respond to the health needs or demands of households. The study findings show there are many areas where CHWs can more actively promote referrals to Rural Health Units and other health centers, as in the areas of child immunization, pre- and postnatal consultations, family

planning, and the treatment of illnesses requiring the technical expertise of other health practitioners.

In the area of preventive health care itself, the survey results indicate several other unmet community and household needs in the areas of sanitation, maternal and child health, and nutrition and other health education. For sanitation specifically, the survey data show that CHWs will have to deal with the problem of drainage systems of communities, unsanitary pig or animal pens, and the still considerable number of households with no or inadequate water facilities, toilets and garbage disposal systems.

For reasons already mentioned in the report, CHWs should also make the health of mothers and women their special concern. Findings reveal that CHWs can improve their efforts in this area by encouraging mothers to consult midwives and other health personnel at least once during their pregnancies and once after birth, if only to ensure that their conditions during these times are normal. (Those exhibiting signs or symptoms of abnormalities must be encouraged to seek medical attention even more frequently.) CHWs can further assist women prepare for their deliveries (place, attendant and instruments), and discuss with women their articulated needs for birth control or child-spacing. In the area of child health, CHWs can devote their attention to encouraging mothers to breastfeed and to have their children immunized. They can further ask mothers to bring their babies to health clinics for periodic check-ups, and educate mothers on the nutritional needs of babies and growing children. CHWs should likewise inform mothers not only on the use of herbals for treating common children's illnesses, but on the use of other simple and inexpensive treatments like ORT, which households in the study do not recall as having been taught them by CHWs.

Many aspects of maternal health and child care are natural topics for health education, but in addition, families may also benefit from general nutrition education that can inform family members on the nutritional value and the proper preparation of certain foods, particularly of those grown in the program communities. CHWs may also wish to conduct health education sessions on household hygiene (personal hygiene, cleanliness in cooking and eating) and on the value of teaching children clean habits from early on. Many of these health education classes can further be supplemented with related reading materials which the study shows have not been utilized as much by CHWs.

Finally, the study suggests likely benefits from pursuing linkages with other government and non-government groups engaged in the larger-scale production of herbal medicines to ensure the wider use of herbals. Similar linkages are also indicated with agencies or organizations engaged in assisting rural households with agricultural production. In upgrading local agricultural production, CHWs can help identify which crops must be grown in the communities to meet household consumption requirements and improve the diets and nutrition of families.

Chapter Three

Case Studies

INTRODUCTION TO THE CASE STUDIES

This section of the report consists of organizational case studies of the pioneering efforts of three agencies in community- based health projects in the Philippines. These three organizations are the Rural Missionaries of the Philippines (RMP), the Council for Primary Health Care (CPHC), and the Community-Based Health Services (CBHS), whose involvement in primary health care began in 1973, 1980, and 1976, respectively. In addition to the case studies, the evaluation has two other components consisting of (1) a survey of household health conditions meant to provide a basis for assessing the impact of the programs at the level of households and communities; and (2) a medical skills test designed to assess the usefulness of the health training provided by the three organizations to community health worker-volunteers. The case studies, on the other hand, were intended to document the structure, management, and administration of the three agencies' programs, thereby providing a context for interpreting the results and findings of the other two components of the study.

Although researched by three different investigators, efforts were exerted to ensure compatibility among the three agencies on several dimensions. Thus, we saw to it that at least a brief history of the organizations be sketched to provide a background for appreciating their current operations and difficulties. In discussing the latter, the three case studies proceed to describe the three organizations' philosophies and principles, They also detail various organizational concerns including services, program administration, and financial management, and their major operational problems. The discussion and analysis of these issues are used in assessing the three agencies' organizational and technical strengths and weaknesses, and the relevance and appropriateness of their thrusts and orientations. These, finally, form the basis for making the concluding observations and recommendations.

As the case studies themselves will show, there are indeed striking similarities among the three organizations, particularly between the CBHS and the RMP. These similarities may not altogether be unexpected, owing to the fact that the CBHS' community-based health program was initiated by the sisters of the RMP. Due to its mandate - monitoring the developments of the different CBHP areas and serving as a channel through which services and assistance can be extended to them - the CPHC differs from both the CBHS and the RMP (although the CPHC briefly and selectively experimented with implementing a community-based program).

The investigators not only dwelt on the same issues but also followed similar research methodologies. Thus, all three case studies are based on information culled from an extensive reading of the three agencies' reports, records, documents, and publications. Interviews were also conducted with past and present program officers at all levels of the three agencies' organization hierarchy, and with CHWs and other non-CBHP health and non-health professionals. Finally, visits were made to a number of program areas to observe activities.

The investigators encountered similar problems as well. A more comprehensive assessment of the three agencies/ organizations would have required a more detailed investigation of each of the above-mentioned aspects. However, owing to a number of constraints, this was not possible. First, owing to the size of the three organizations and the magnitude of their operations, and to time and

resource limitations, only a number of program areas could be visited. The latter is particularly true for the CBHS and RMP. Thus, only conditions obtaining in these limited areas, which may not be typical of all areas, are described in the report. Secondly, former officers and personnel who could have provided valuable information on relevant issues could not be located for interview. Finally, not all important documents required for a comprehensive review were available, and quantitative and other kinds of information were not consistently recorded (or were recorded in various formats) making longitudinal comparisons difficult to make. The three investigators are confident, however, that sufficient information was gathered that permits at least the broad description of the various dimensions of the three organizations, and for drawing some conclusions on, and recommendations for the CBHS and RMP community-based health programs and CPHC's coordinating activities.

Rural Missionaries of the Philippines

Community- Based Health

Development Program

A Case Study

by

Judy Tagulwalo

Introduction

The credit of popularizing community-based health programs may appropriately belong to the Rural Missionaries of the Philippines, the rural apostolate arm of the Association of Major Religious Superiors who pioneered the alternative health care approach in the Philippines in 1973. The Rural Missionaries' (or RM's) Community-Based Health Development Program antedates the Philippine government's early attempts at instituting primary health care programs in 1975. Both RM's and the latter government programs are founded on basically the same principles of building community-led and popularly supported health care programs. But, given known differences between the government's resources, management, and orientation and those of non- governmental groups, there are reasons for expecting differences in the development and directions of state-sponsored primary health care programs and the CBHPs of the RM and other private agencies.

This case study of the RM CBHDP is based on extensive reading of reports, records and materials maintained by the program, as well as on interviews with program officers and key informants and visits to RM-CBHDP areas. (See Appendix A for a list of these sources of information.) The case study details the growth, expansion and changing strategies of the RM's community health programs as well as an evaluation of its guiding philosophies, principles and objectives. In describing the various dimensions of the RM-CBHDP, the case study hopes to offer a basis for assessing organizational and technical strengths and weaknesses of the program and the appropriateness of the program's thrusts and orientation over the period 1973 to 1989.

At present, CBHDP acts as a coordinating and resource center for Catholic Church initiated or related health apostolates and community-based health programs. It extends the following services:

1. technical and consultative services in setting up, strengthening and expanding CBHPs;
2. in-service training for program staff;
3. coordination;
4. education, orientation, training services and network building; and
5. referral services.

RM CBHDP works with two types of church related programs. The CBHDP-initiated programs are those funded and directly managed by the Rural Missionaries. The RM CBHDP-assisted or coordinated health programs are those which are not funded nor directly administered by the RM-CBHDP. These programs are managed by non-RM church people but call on RM CBHDP for assistance in setting up and managing the program, in evaluating it, and in staff training.

As of the end of 1988, RM initiated CBHPs covered 432 villages in 79 towns of 15 dioceses in the country. The dioceses are spread out with about half concentrated in the Luzon provinces. A total of 2,909 community health workers perform front line functions at the grassroots level.

In 1988, the program had 59 full-time staff members, 28 of whom are health professionals while the rest are non-health professionals. The health professionals included 4 doctors, 13 nurses, 9 midwives, one medical technologist and one chemist. Twenty members of the staff are RM sisters belonging to different religious congregations.

CBHDP's policies and directions are set by the National Convention and National Board of the RM. (See Chart 1.) The National Convention, held every two years, is the general assembly of all RM sisters, priests and brothers. The RM National Board. composed of the RM National Coordinator and eight sub-regional coordinators, meets at least two times a year to evaluate the progress of the programs and to decide on immediate matters. Internally, the RM CBHDP has a coordinating body which meets once a year to oversee the work of the health program at the national level. This body is composed of four RM sisters, who coordinate the health program in the regions, and two members of the National Health Office. The Manila-based National Health Office composed of five members takes care of the day-to-day management of CBHDP. At the diocesan level, a diocesan health team, with four to five workers, administers the work at that level. A local health staff, usually composed of a health professional and several community health workers, functions at the parish level. Finally, community health workers each of whom covers an average of 15 to 25 families are the links of the program at the village level. (See Charts 2 and 3.)

Philosophy and Objectives

The RM CBHDP is premised on the belief that health is not merely the absence of illness but rather is a state of "total human development" which can only be achieved in an "atmosphere of economic prosperity, freedom and justice." The RM CBHDP views health as a basic human right that should be enjoyed by every citizen who should have access to effective health care services. It considers health problems as interrelated with the broader socio-politico-economic problems of society and believes that only the over-all transformation of society can lead to long lasting solutions to the country's health problems. These solutions can be achieved only by the concerted action of the people themselves.

Based on the above philosophy and vision, the program defines its general objectives as the building of just communities that will ensure total human development through awareness raising, organized community action, self-reliance and people's participation. To achieve this end, CBHDP set for itself the following specific objectives:

1. to train volunteer community leader-health workers, elected by their own communities;

Chart 1. Relationship of RM CBHDP to RM National Board

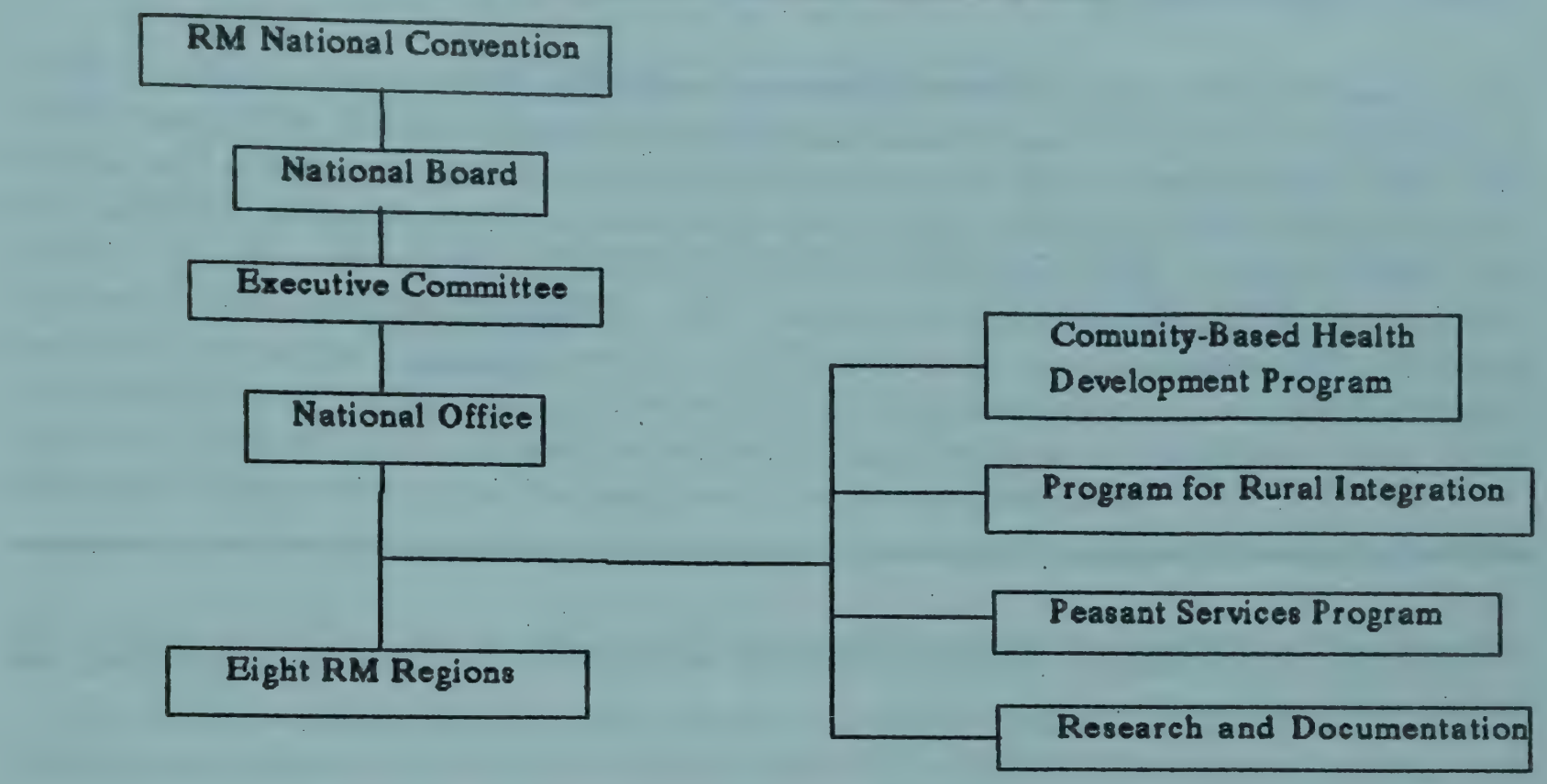


Chart 2. Organizational Structure of the RM CBHDP

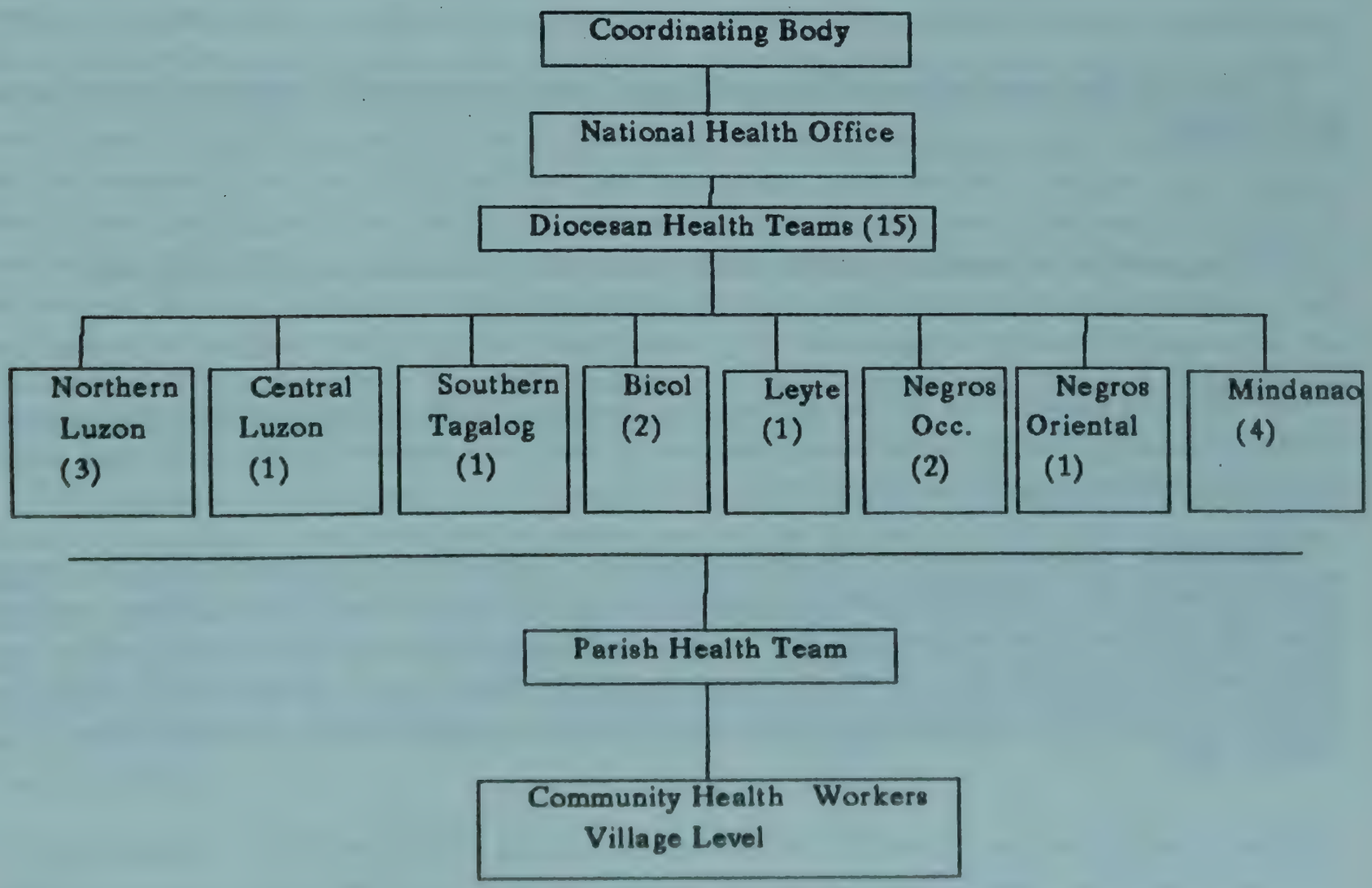
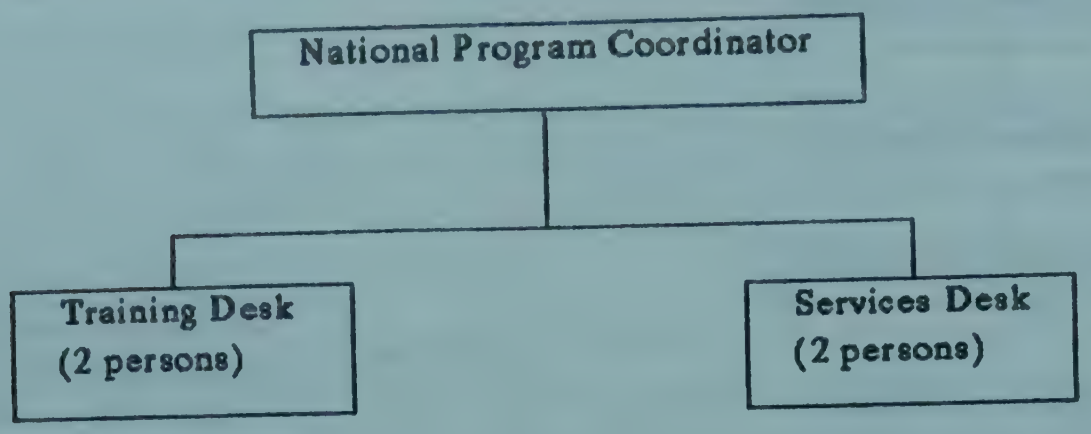


Chart 3. Organizational Structure of the RM CBHDP National Health Office



2. to build local community health organizations which will be instrumental in identifying and helping solve basic health needs;

3. to develop self-support systems for primary health care in each local community;

4. to provide field experiences in community-based health programs for interested students and professionals;

5. to improve the utilization of existing health resources, government, church and private.

Not explicitly stated in the written philosophy of the RM CBHDP is the Christian underpinnings of the program typified by the following statement of one of the pioneering RM sisters who stated in the first RM National Assembly in 1986:

The (health) program is part of the healing ministry of the Church. Our health work has always a biblical basis. It is patterned after the healing work of Christ. Our health work gathers strength from the initiative of the people. It should be dedicated to eradicating the roots of the problem and should always be within the context of liberation. At the same time, it situates itself within the context of our Christian faith (Proceedings of the First National RM Health Assembly, May 18-22, 1986, p. 23).

Background

Since its start in 1973, the RM CBHDP has gone through several major periods of development. A 1985 report of the National Health Office defined four periods on the basis of the evolution of the program's orientation and the extent of program propagation. The first period covers 1973-1976 and is described as the program's beginnings. The years 1976 to 1978 is the period when the health program became known and was popularized as the community based health program (CBHP). The third period, which were the years 1979 to 1980, was the period of reevaluation. The fourth period, then merely defined as "the current period" in the RM document refers to the years 1980 - 1985 and may be described as the continuous propagation of the RM health approach and health program. The period from 1986 to the present marks the continued existence of the CBHDP under a new government administration after the overthrow of the Marcos government.

The First Period (1973-1976): The RM Health Program's Conceptualization and Initial Popularization

Prior to the setting up of the health program, the Rural Missionaries did not have specific programs and activities as the arm for rural apostolate of the AMRSP. RM sisters went to the rural villages and combined evangelizing work with assisting the rural poor based on individual initiatives. In 1973, three RM sisters (a nurse, a chemistry graduate and a catechist), assisted by an ailing physician nun, convinced that the rural poor had no access to appropriate and needed health services as government and church programs were generally not available to them, decided to set up an alternative health program. In place of the prevailing health care delivery system which is western-oriented, urban based, and monopolized by health professionals, the sisters envisioned a developmental health program that would encourage and train lay people to meet the health needs of the community and would utilize local and indigenous resources for preventive and curative health care. Starting with the training of paramedic workers in depressed urban and rural areas in and around Metro Manila, the sisters, then known as the RM health team, set up three pilot areas in some of the most underdeveloped areas in the country whose bishops showed interest in and willingness to support the program. Twenty seven (27) barangays in fifteen (15) towns of the Dioceses of Ilagan in Isabela (Luzon), Tacloban in Leyte (Visayas) and Iligan in Iligan Norte (Mindanao) were the areas initially covered by the program.

The program conducted year-round orientation seminars nationwide resulting in numerous requests by traditional institutions and organizations such as the parish church, the village officials and the barangay councils. In setting up the program in the dioceses, the staff introduced the orientation of the program to Church officials and parishioners, selected and trained the local staff and propagated the concept of the program to health institutions and professionals in the areas. They also went to the barrios to conduct seminars and to train community health workers. A CHW manual and trainor's guide served as the basic text for the popularization of the program and for training CHWs.

By the middle of 1976, with three pilot areas in place, the RM Health Team expanded its service areas in response to the requests of other dioceses. While the Health Team continued to monitor

existing programs and to provide training to health workers in the pilot areas, new programs were started in Northern and Central Luzon and other parts of the Visayas and Mindanao.

A major development that greatly influenced the philosophy of the health program during this period was the introduction of structural analysis in studying the health system of the country. This method of analysis was introduced in 1975 by a representative of FERES, a French organization, during a conference of bishops, priests and social action directors who in turn echoed its content to other church groups and individuals. The RM Health Team used this analytical framework to study the health situation of the Philippines which showed how existing political, economic, and cultural structures have hindered the development of an adequate and effective health delivery system in the country as part of the Basic Orientation Seminar-module of the program. Ill health is a result of difficult working conditions, inadequate nutrition and shelter, lack of access to professional care, and a culture that bound the rural masses to ignorance and superstition. To address the health problems of the community, therefore, it was not enough to develop paramedics from among the poor; but it was also necessary to organize the poor to address their poverty and powerlessness that are the root causes of their problems.

The Second Period (1976-78): The Rapid Popularization of CBHP, Community Organizing as an Integral Part of the RM Health Program

Community organizing methods became a major strategy of the RM's health program as a result of its adoption of structural analysis. Health program organizers were trained not only on basic health skills but also on the principles and methods of community organizing. The health program then became an entry point for organizing rural and urban poor communities towards self reliance in health needs and in achieving their economic and political aspirations.

By the middle of 1976, RM's health program became known as the community based health program (CBHP) precisely identifying it as not merely a paramedic training program but one where the community as a whole is involved in transforming the health situation of the locality. The training of volunteer community health workers went hand in hand with community organizing work. In addition to health skills, community health workers were trained to set up community organizations and to lead community mobilizations.

At the national level, seminars and orientation workshops as well as exposure programs, where health and other interested professionals were brought to CBHP areas, facilitated the rapid popularization of CBHP. By October 1978, there was a community based health program in 160 villages in 35 provinces or a growth of almost 179% in terms of number of villages covered since the start of the pilot areas in 1975. More medical professionals were also involved in the program. In 1975, only five were with the RM Health Team while in 1978 this rose to 69. Unfortunately, there is no data on the number of CHWs trained during this period nor the number of people's organizations set up through the health program.

1979 - 1980: Reevaluation of the CO Approach of the Health Program

Community organizing which had been integrated into the CBHP philosophy was subjected to criticism in 1979. The method's main limitations were 1) its failure to take into account the heterogeneous composition of the rural population and 2) the method's emphasis on local problems and its inability to relate these to national issues. These two factors hindered the development of broadly-based people's organizations and the evolution of leaders and organizations that represent the poorest and most powerless among the villagers. This reevaluation of the CO approach led to a reorientation of the health program. While the RM health program maintained its community based approach, it centered its thrust on the most exploited and oppressed, and consciously developed organizations which combined local and national demands. RM CBHP organizers began to identify the poorest among the village residents and encouraged them to actively participate in the health seminars and trainings. Through this method, more and more community health workers were elected from among the most destitute residents of the barangays. Organizations of farmers and women were helped set up to encompass not only the barangay but the town and province as well. These organizations addressed not only the lack of local health and sanitation facilities but demanded the implementation of genuine land distribution and higher wages for farmers and farm workers.

1980 - 1985: Implementation of the Refined CO Approach

The first half of the 80s saw the wider implementation of the refined CO approach to the health program. It was reiterated that health programs to be truly effective in alleviating the causes of ill health should be carried out within the framework of social transformation. Emphasis was given to awareness building and leadership training. At the same time, with the growth of more CBHPs due to the involvement of other institutions (the National Council of Churches in the Philippines, for example, had set up the NEHCC and the Council for Primary Health Care) and the rise of people's organizations all over the country, RM CBHDP began providing assistance in forming health committees of people's organizations while maintaining its former function of setting up health programs in unorganized areas. And to achieve better coordination among other national CBHP institutions and avoid duplication, an inter-CBHP consultation defined the concentration of different agencies involved in CBHP. The RM CBHP, now known as RM Community Based Health Development Program or RM CBHDP to differentiate the national agency from the health program, decided to focus on Catholic Church initiated or related community health programs. Its main functions became monitoring the programs, meeting the training, health care education and research needs and facilitating exchanges of experiences and resources of the different CBHPs under church sponsorship.

1986 to the Present: Continuation of the Health Program's Thrust Under a New Government Administration

The change in government from the Marcos regime to the Aquino administration did not bring about major shifts in the orientation of the RM health program. While the donor agency initially brought up the possibility of ending financial support to CBHDP and rechannelling the funds to the new government, the RM agency successfully convinced the former that the magnitude of the health problems in the country is such that non-governmental organizations focusing on health are still needed. More importantly, as the RM health program's beneficiaries are in the rural areas where the euphoria was not shared as the land problem and militarization remained pressing issues, the continued need for the services of the RM health program remained. Thus, CBHDP persisted with its thrusts of helping consolidate existing CBHPs and setting up new ones and improving its training and health service components. Emphasis was placed on consolidation as reflected by a series of national training and assemblies held from 1986 to 1988 where health staff members discussed and united on the goals and methods of the health program. By the end of 1988, the CBHDP covered 432 villages, 79 towns and 15 dioceses.

Setting Up the Program at the Local Level

The RM health staff initiates the community based health program at the village level either through the church, through people's organizations or directly with the villagers.

In the first approach the health program is started as a response to the request of a local bishop or parish priest. In the second, a people's organization asks for assistance from the Rural Missionaries in setting up its health committee. In the third approach, CBHP work is started by working through the barangay council.

In non-organized villages, the setting up of the health program whether through the sponsorship of the parish priest or the barangay council, consists primarily of developing health workers from among the people. Village and sub-village assemblies are held by the program staff to discuss with the people the objectives and methods of the program. An initial health survey of the village is made by the staff assisted by village volunteers. Finally, another series of assemblies is held to discuss the concrete health needs of the community, the necessity for having community health workers and the process of selection of the latter. Community health workers are then selected by the villagers and are given training on basic and advanced health skills.

The CBHP is considered in place once enough CHWs are trained and have shown capability to meet the basic health needs of the village. Quantitatively, this means that between 50% and 60% of

the village population is reached by the CHWs with each CHW serving 10 to 15 families. CHW capability is measured in terms of their ability to start health campaigns such as immunization and deworming drives, to mobilize the villagers in setting up herbal gardens or building the village clinic and to run the clinic and village drugstore. Once the CBHP staff has evaluated the extent and quality of CHW services and skills and found them satisfactory, they turn over the direct management of the program to the CHWs. The RM health staff's role from then on is limited to monitoring the progress of the program in the area and providing further training to the CHWs. This process takes from two to three years, a period of time essentially dictated by the two years needed by the CHWs to finish the basic and advanced leadership health skills training.

In places where people's organizations exist, the work of the organizers are generally easier. The organization provides the data on the local health situation, ensures that the program's orientation is disseminated among the members and selects the members of the health committee. The organization's village-level health committee is composed of three to five persons and health teams, also with five members work at the purok or sub-village level. The members of the health committee and health teams undergo the same health skills training that is given to CHWs in unorganized areas.

The work of starting a health program in unorganized villages is facilitated by entry through the church which introduces the program to the people by announcing it during masses. Entry through the church also facilitates the acceptance of CBHP organizers. Problems with members of the church hierarchy may, however, arise once the work proceeds. Church officials sometimes make demands which organizers feel are overly burdensome, such as the prompt submission of their complete daily activities report. Failure to meet these demands may lead to a breakdown in communication between them and church officials which take time to resolve. Problems of this type are resolved through the intervention of the diocesan health program coordinator who sets up a dialogue between church officials and the organizers. Efforts are also made by the diocesan health program staff to invite church officials to attend CBHP orientation meetings or the monthly in-service parish health workers meeting so that they can have a better grasp of the health program.

The CBHDP National Coordinator estimates that 70% of health programs is church sponsored while 30% has been initiated through people's organizations. The number of programs established through the barangay council is negligible.

Education and Training Services

Providing training for CBHP staff members, community health workers and interested medical and non-medical volunteers to the program has been important service component of the RM CBHDP.

Compared to those provided during the early years of the program, current training services offered by the RM CBHDP are broader in content and scope. During the first ten years of the health program (1973-1983), there were only three basic modules in use: the CBHP orientation, Basic

Health Skills Training, and CHW Trainor's Training. The number of trainings and participants were also limited. The RM CBHP Evaluation of 1975 to 1983 reported only 47 seminars with 322 participants or an average of six (6) seminars and 90 participants per year. In contrast, current training and seminar courses are more varied in response to the need to arm CBHP workers with more skills and knowledge. The courses now include Basic Health Orientation Seminar, Basic Health Skills Training and Advanced Health Skills Training. (See Appendix B and C for outlines of each course.) In addition, leadership and organizing courses are also taught which cover such topics as Community Organizing Skills Training (COST), Teaching Learning Seminar and Program Management. In the years 1986-1987, 34 seminars, consisting of its basic health training and 12 advanced skills training attended by 344 participants were given. In 1988, more than 17 training seminars on the different courses were attended by a total of 502 participants.

The training desk of the National Health Office is responsible for the outline and curriculum design of the training courses. Its staff acts as resource persons for trainings held in the areas. CBHP staff at the diocesan level are responsible for writing out the detailed texts of the courses using the outline provided by the National Health Office. All program areas have formulated the basic set of training materials in the local dialects and the more advanced ones like the RM-assisted program in Isabela have also included a lesson plan based on the text for the trainor. However, copies of these texts are usually in mimeograph form and their distribution limited to the trainors, while the CHWs are expected to rely on handwritten notes taken during the training. Some trainors improvise by making/preparing teaching aids and handouts.

The Basic Health Training is given in the parish or village usually by a diocesan health worker assisted by an apprentice trainor who is oftentimes a tested community health worker being eyed to become a regular staff member of the diocese. The training, if given in one seating, takes about a month to finish. In practice, however, it is given on a staggered basis which takes from six months to one year to complete. From eight to eighteen participants attend a training which is usually held for three days a month. The staggered method of training has been adopted because of the difficulty of holding the training in just a one 3-day seating. Economic reasons and family responsibilities make it impossible for the CHWs to be away for periods longer than three days. The break in-between training sessions allow the CHWs to use their initial knowledge in their work with the community and facilitates internalization of the concepts.

A 1988 assessment revealed that the training capability of the different RM health programs is limited to the basic level while staff development and advance training are usually provided by staff members of national and regional offices. There is a need for a comprehensive evaluation of training modules and methods to assess the curriculum designs, texts, teaching aids and methods of instruction currently in use.

The Health Services

The National Health Services Desk of the RM CBHDP was started in 1986 in response to the need for coordination and technical assistance for basic health care secondary and tertiary health

care which local programs and local health facilities cannot adequately meet. The health services of the RM CBHDP originally aimed to provide primary and secondary health care (medical and dental) to the RM network through mobile clinics and medical and surgical missions. With the growth of the health program and its network of health institutions, a referral system has been set up to take care of health problems beyond the capabilities of the program. However, because of the inadequacies and limited capabilities of health facilities in the provinces and the need to avail of the more advanced health facilities in Metro Manila, the RM CBHDP has set up a referral center for patients from local programs as part of its health services.

At present, the health services of the program consist of organizing medical and dental missions to the rural areas, acting as referral clinics for patients from the regions; helping in conceptualization and setting up health care services; assisting local staff in community health campaigns; networking with health institutions and professionals for referral purposes as well as soliciting medical equipment and supplies for program areas. The health services desk has set up a network of 15 health agencies and 62 doctors to form a referral network. Guidelines on referrals have been formulated to systematize and clarify the priorities and requirements for making referrals to the national office.

Since it was established, over 100 patients have been assisted by the referral center. Medical and and surgical missions have been organized in coordination with dioceses, hospitals and private health organizations. In 1986, seven provinces were covered by three missions and 80 health students and 72 health professionals worked together to attend to over 25,000 medical patients, around 12,000 dental cases and more than 1000 surgical patients. In 1987, a barrio medical and dental mission and an EENT and surgical missions went to Isabela. Thirty doctors, eight dentists and 80 medical and nursing students participated. The medical and dental mission covered five CBHP areas in the provinces and treated over 1,000 patients, 154 dental patients and 112 goiter patients. The EENT mission examined 256 patients and operated on 55 patients with eye troubles.

In 1988, no medical mission was organized although the health services staff joined a medical relief mission to treat victims of military burning and bombing of villages in a Visayan province. They also joined relief operations for victims of typhoons which struck the country in the latter part of the year. At the national level, the provision of health services is hampered by inadequate material and human resources. Medical equipment and supplies are lacking and the enthusiasm of health students and professionals in joining medical missions have tapered off in the past two years principally because of the instability in the rural areas as the armed conflict continues to escalate.

Referral centers have also been set up in the provinces to provide secondary health care to patients from the villages and as a venue for the further training of CHWs. In Isabela, the referral center of the Diocesan Health Program set up in 1986 was built from financial and material donations of a group of Japanese physicians who went on exposure visit to the area in 1985. The center has three beds for out of town patients and laboratory facilities for simple urinalysis, sputum examination, blood smear testing and hemoglobin count. It operates daily and is run by one of the members of the Diocesan Health Staff, assisted by a community health worker. To maximize the number of CHWs who can benefit from working in the center, CHWs from different villages take

turns in doing three-day duty in the clinic. The center is also the site for the bulk preparation of herbal medicine and its herbal garden the source of cuttings for propagation.

In Negros Occidental, a newly opened CBHP clinic in a town center also operates daily. Housed in a government building which was donated to the parish and located adjacent to the church, the center's equipment and materials have from donations of the parish priest and some members of well-off families of the town. The center has basic surgical and dental equipment and laboratory facilities. Herbal medicine in tablet or bottled form are stored in the clinic. As in the Isabela center, the one in Negros Occidental is managed by a full time health worker assisted by CHWs who work on rotation. Aside from the regular clinic in one parish, village clinics are also located in other parishes served by the program. Usually located adjacent to the church, the clinics consist of one room structures made of native materials. However, most of these are open only if a village clinic is held, usually once a month. During clinic days, the program staff together with volunteer doctors or dentists from the area and assisted by CHWs hold medical and dental consultations.

The programs in both Isabela and Negros Occidental charge patients a minimal consultation fee of P8.00 and a surgery fee (for circumcision) of P10.00, rates which are way below the P20.00 consultation fee and P50.00 circumcision pay charged by private doctors in the provinces. For herbal medicines, a standard price of P0.50 per three tablets is charged. The program's clinic at the local levels, therefore, not only provides needed medical and dental services at a minimal fee to the people, but also is a venue for involving concerned private medical practitioners in the program and provides an opportunity to explain the concepts of the health program to the beneficiaries. In addition, the clinic also serves to further establish the credibility of the CHWs among the people as they perform vital functions during the clinic.

The daily work of the CHWs consists of extending basic treatment to individuals who go to them for assistance. In Negros Occidental, CHWs interviewed cite acupressure and the use of herbal medicines as the common treatment they use. Some of them can perform minor surgery (wart removal and circumcision) under the supervision of a program staff. In Isabela, CHWs services include, in addition to those mentioned by the Negros Occidental CHWs, prenatal care, and treatment of TB patients. Referrals to the Rural Health Units, specifically to the rural midwife, is a common skill possessed by CHWs. A cursory assessment of the level of services extended by the CBHDP program made by the Third National RM Health Assembly in 1988 pointed to the need to evaluate the impact of the services extended by the program on the concrete health needs of the community. Aside from the evident fact that the actual coverage of the services is less than the targeted clientele because of inadequate resources, there seems to a be a need to identify whether the services extended actually meet the priority health needs of the community.

Networking

Developing links with other organizations is an important component of the RM CBHDP. Through networking, the institution propagates the concepts and objectives of its health program;

generates human and material support and over-all advances its goals. The RM CBHDP works with other private health programs, health organizations and government health officers.

The program has, from the beginning, attempted to forge good working relations with the government's health agency, the Department of Health (DOH). The Secretary of Health in 1973 endorsed the program of the RM Health Team which endorsement became a regular feature in the manuals and guides published during the early years. In the pilot areas of Isabela, Leyte and Iligan, local health officials were invited to participate in the program. In Leyte, for example, a member of the advisory board of the CBHP came from the provincial health office. In the latter part of the 70s, a number of medical graduates who were then required to do rural practice worked with CBHPs in the provinces. They not only supplemented the health force of the program for six months, some of them chose to work with the program after the required period of rural service ended. At present, the RM CBHDP cooperates with the government's Department of Health on specific concerns. The agency collaborates with the DOH on the TB control and immunization programs, and are active in coordinating with it at the national level on the government's TB Control Program and Rural Health Practice Program.

At the local level, most of the local CBHPs relate directly with the Rural Health Units. For their TB control program, community health workers collect the sputum smear from suspected TB patients and bring the smears to the RHU for laboratory testing. The CHWs also ensure that the patients in their villages receive their month's supply of medication from the government health office and ensure that these are taken regularly. In Isabela, the working relationship with the provincial health office has so developed that medicines earmarked for TB patients in CBHP areas are turned over in bulk to the program. This has proven beneficial to the TB control program because DOH personnel are essentially confined to the town centers and most of the patients in the villages are too poor and too embarrassed (the stigma of having a communicable disease has not been removed) to keep going back to the government clinic.

In the government's immunization drive, the community health workers do the groundwork preparatory to the actual immunization in the area. A survey of children needed to be immunized is made, the benefits of immunization discussed with the parents through house visits and the date for immunization is arranged with the parents and the rural health office. On the day of the immunization itself, the rural nurse or midwife brings the vaccines to the village and does the immunization while the CHWs assist her. The local CBHP staff is encouraged to relate with the government's health agencies and personnel in the area. New CBHP staff members usually make a courtesy call to the provincial and municipal health officers to introduce themselves and the program, and to discuss possible areas of cooperation. A breakthrough of sorts in cementing closer DOH-RM CBHDP relationship was an inter-agency health program consultation held in Isabela in October 1988. Sponsored by the Diocesan Health Team of the province, the consultation aimed towards better coordination and implementation of people health-oriented programs and was attended by almost 30 government health personnel including several municipal health officers. The consultation resulted in a better understanding of the CBHP by the government health personnel which made possible easier coordination with them. In Negros Occidental, municipal health officers are called on to act as resource persons for CHW assemblies to give input on the health situation

are called on to act as resource persons for CHW assemblies to give input on the health situation of the town using government statistics. In the same province, a joint government and CBHP celebration of Health Worker's Day was started this year.

There have been, however, irritants in the relationship between RM CBHP staff and the government health agencies. A major one in Bicol revolved around an experimental program of the DOH to control Vitamin A deficiency which the village people denounced as having caused deaths of a number of mothers and children. To this day there does not exist a working relationship between the RM health program in the area and the government health agency. In one province, the request of the local CBHP staff to the provincial health officer for a copy of statistics on the health situation of the province was summarily denied without any explanation. In other areas, rural health workers of the government sometimes do not show up for scheduled mass immunizations resulting in wasting the time of and ill feelings among the villagers. However, these are generally isolated cases and the CBHDP generally characterize its relationship with the DOH as essentially collaborative. The RM CBHDP relates with the two international health agencies, the World Health Organization and the United Nations International Children's Fund (UNICEF). CBHP personnel attend consultations and meetings with these agencies to discuss health problems and strategies. The program from time to time receive books and materials from them. But needed medical supplies such as vaccines cannot be obtained from these organizations as they channel drug and equipment donation only to government health institutions.

The National Health Office of the RM CBHDP also works with other non-governmental health institutions such as the National Ecumenical Health Concerns Committee (NEHCC), the arm of the National Council of Churches in the Philippines for Protestant related health programs, with the Council for Primary Health Care (CPHC) which acts a resource center for non-sectarian health programs and with the Health Desk of the Urban Missionaries.

The RM CBHDP also works with sectoral and multisectoral groups. It facilitates exposures for members of the Philippine Youth Health Program in the program areas. It has links with the National Council for People's Development, a consortium of cause oriented organizations established to develop socio-economic work among the people. The agency's particular role in the consortium is to situate health considerations in the concept of people's development. It also actively propagates the CBHP orientation among different people's organizations through seminars and symposia and helps conceptualize and set up health programs of some of them.

Finally, a major thrust of RM CBHDP is to relate with religious congregations, church organizations, and other religious groups with health concerns. Rm CBHDP's networking efforts with these groups take the form of advocacy, by propagating the community-based approach to health care delivery, and by offering its knowledge and skills in setting-up community based health programs, training program staff members and health workers, and managing such health programs. Among the organizations to which RM CBHDP has offered their services in recent years are the Sisters Formation Institute, the College of Nursing of St. Paul's, the Episcopal Commission Health Services, CCF, the Canosians, the Camillian Sisters and St. John of God.

The Community Health Workers

The community health workers (CHWs) provide the crucial link between the program personnel and the people. The realization of the program's objectives and the continued expansion and improvement of the health services of the CBHPs lie in the final analysis in the effectivity of the community health workers who act as the frontline personnel of the program.

The criteria for choosing the CHWs have not basically changed from the original ones used at the beginning stage of the program. One of the three sisters who originated the health program recalls them in a recent interview:

> "They must be people with a strong desire to assist their fellow villagers and must have high respect for them. Formal education was not a prerequisite but potential CHWs must have a certain degree of life experiences. Hence married people with children were deemed more qualified to become health workers because they will have had experiences in coping with sickness in the family. Preference was given to those who show potential for leadership rather than those already in leadership positions in the village and thus would have had less time for the program."

The CBHDP coordinator relates almost similar criteria in the choice of current CHWs:

> "They must be respected by the barrio folks they have the interest and inclination to provide medical services to the people and have the time to perform such services; and they must be permanent residents of the village with no immediate plans of changing residence."

Interviews with several CHWs from Negros and one from Isabela essentially confirmed the use of the above criteria. The CHWs relate that they were chosen by the villagers in a community assembly because the people found them approachable and they are trusted by the people. The CHWs volunteered for the program because they realize the gravity of the health problems in their community and were happy that they could do something about them. Also, for those who had little formal education, becoming a CHW was an opportunity to gain further knowledge that they could not otherwise afford to get.

While there is as yet no systematic study of the socio- economic background of CHWs, interviews with program personnel and CHWs revealed a general description of the average CHW. She is usually a woman in her late twenties or early thirties, with four to five years of schooling, married, and belongs to a farming family. The fact that an overwhelming number of CHWs in the program are women is attributed to the traditional role of women as healers in the family and their concern for the health needs of their families. The CHWs describe their role as healers and educators of the community. Aside from training and seminars they attend, the activities of the CHWs include echoing the content of the training to their fellow villagers; serving as the local paramedic on call 24 hours of a day; preparing and dispensing herbal medicines; coordinating with the government midwife for immunizations and TB control programs; making referrals to government clinics; and

mobilizing their community for health campaigns. In parishes where a regular clinic operates, CHWs report for clinic duty on a rotation basis. They also arrange village clinics where they develop their skills in mobilizing people.

CHWs are expected to re-echo to the community the entire Basic Health Orientation Seminar and portions of the Basic Health Skills module dealing with preventive and basic curative health care. Thus, as educators, CHWs are creative in finding ways to re-echo the content of trainings they have undergone. Group discussions may be held prior to a parish feeding program while the mothers work together preparing the food. Or, it can be an informal gathering of four to five neighbors on a relatively free afternoon. However, the most frequent method of instruction is the one-on-one sharing during house visits which the CHWs are expected to do on a regular basis. Trained CHWs who have completed both basic and advance health skills training have several choices in further honing their skills and expanding their reach. Some become staff members of the program at the parish or diocesan level and become trainors and organizers of CHWs in other villages. Others who have shown inclination towards a specific field such as dentistry or laboratory analysis can pursue additional courses on these topics and act as parish specialist in this field. Still others become leaders of people's organizations such as a farmer's or a rural women's association which has been formed as an offshoot of the health program.

While there has never been a lack of enthusiastic volunteers for CHW training, the health program suffers from a high rate of drop outs and/or passivity. The 1988 national health office report places the drop out rate at almost 20%. The reported rates for Negros Occidental and Isabela for the same year are much higher: 48% and 50% respectively. The primary reason behind the high drop out rate of CHWs appear to be economic. Many of the CHWs come from the poorer families whose sources of livelihood depend primarily on their share of the harvest or their wages as hired farm workers.

CHWs do not receive any honorarium. There are two main reasons for this. The most obvious is lack of funds. The budget of the program is barely sufficient to support 60 full time personnel. However, an attempt to provide a P200 honorarium to some CHWs was made in Negros Occidental in 1985 through the initiative of an RM coordinator. Since the funds raised for the honorarium was limited, only two CHWs from each parish could be subsidized. The program staff discovered that only the CHWs receiving the honorarium were performing their work while the rest became inactive. The selective mode of paying the honorarium also created antagonism between the paid and unpaid CHWs. When the allowance was stopped after less than a year when funds ran out, majority of the CHWs who used to receive the monthly subsidy became inactive.

Another reason why CHWs are not paid is premised on the belief that the dynamism of the health program lies in the spirit of volunteerism and community support for it. But as almost all of the communities being served by the CHWs are depressed agricultural areas where families barely eke out a subsistence living, even transportation money for seminars or training outside of the community is already a burden. Community assistance in the form of donated roootcrops and vegetables for CHWs is the most common form of assistance. A laudable but still isolated case was a community effort to enable a CHW to attend an important national training held during the harvest season. This particular CHW would have missed the training so as to do harvest work and accumulate grains (wages are in kind during harvest) for her family. Her fellow villagers instead shared

with the family part of the grains they have harvested making it possible for the CHW to attend the training and still fulfill her family obligations.

Other sources of support for the CHWs come from the parish priest. In relatively well-off parishes, the parish priest defrays the transportation cost of the health workers when they have to attend seminars in the diocesan center. In poorer parishes, the priest would endorse a solicitation letter to raise funds for the CHWs which the latter would take to some prosperous parishioners.

To enable the CHWs to raise their own funds, the program in Negros has come up with a policy of dividing the consultation and service fees between the program and the CHW fund. For example, the P10 circumcision fee charged during parish medical consultations is divided evenly between the program and the CHWs. Five pesos goes to pay for the anesthesia and other clinic needs (cotton, syringes, etc.) while the other P5.00 goes to the CHW fund. Payment for herbal medicines also goes to the CHW fund. This fund is a collective one and is used to defray expenses for herbal preparation and to purchase medical equipment. In Negros, the parish CHWs have bought a blood pressure apparatus from their fund on arrangement with the program staff. The apparatus which costs P550 was bought from program funds and the CHWs pay a monthly installment fee of P50 until the whole amount is paid. The collective fund is also the source for payment of mimeographing costs of record forms used by the CHWs. The program staff does a monthly audit of the fund. Donations to individual CHWs for medical services rendered to individual clients are considered personal income. But the CHWs are encouraged by the program staff to give part of the donation to help build up the collective fund.

Loans from the CHW fund for personal expenditures are not encouraged. Instead CHWs usually approach the program staff to borrow from them. But as the credit sources are an important need for CHWs, a number of organizations are trying to set up a credit cooperative by sponsoring raffles.

Military harassments of CHWs (discussed in more detail in the section on the effect of the armed conflict on the program) is another major reason behind the CHWs' passivity. Health workers in areas where a strong revolutionary presence is suspected by military authorities are branded as "rebel medics" and are harassed, arrested or even killed. Military propaganda labeling the health program as "communistic" because of its focus on total social transformation and threats from landlords to evict tenants who have joined the program have scared off a number of CHWs.

A major effort to consolidate the health workers and to address the two major causes of CHW inactivity is the formation of CHW organizations in the areas. The CHW organization is envisioned to unite all CHWs in the particular area towards achieving common goals and to serve as a mutual aid society that can offer an organized response on behalf of CHWs facing economic and political difficulties. Almost all of the RM program areas have existing CHW organizations except for two which are in the process of setting up the core of the organization. For example, the CHW organization in Isabela is part of a region wide federation covering Northern Luzon. The region wide organization is in place with working structures from the region down to the village level. The organization holds regular meetings to assess its work and to plan out activities. In Negros Occidental, the outlines of a CHW organization is being formed with the recent election of the CHW Executive Committee composed of a CHW representative from each parish. The CHW organization

is envisioned to take over the management and running of the health program in the community with the program staff gradually turning over these functions to it.

Community Support

The concept of CBHP underscores the crucial role that community support plays in the success of the program. The emphasis placed on organizing by the health program is based on the analysis that health problems are just a manifestation of the broader social inequities in society that only organized people's actions can transform.

Community support for the health program is viewed as a starting point for community involvement in national and other local issues. On another plane, the program believes that already organized communities are in a good position to support and sustain health programs carrying the CBHP orientation.

As the RM health program principally operates through the church, support for the program by the bishops and the priests is usually a requisite for gaining community support. Interviews revealed that while this support is generally present (the program has so far met difficulties with only one bishop who has consistently refused entry of the program to his diocese because of political considerations), the extent of the support depends on the individual religious' grasp of the significance of the program and the resources at his command. One excellent example of all-out support extended to the program is that given by the Bishop of Ilagan whose diocese became the site of one of the first CBHP pilot areas in the country. Two years after the program started, the diocese took over the management and running of the program under its Social Action Committee. To this day, the Diocesan Health Program of Isabela remains faithful to the spirit and orientation of the CBHP. (One important factor for this aside from the church's support is the continuous stay of the RM sister who has been with the program since 1975.) The diocese, in addition to providing the funds for the health program and donating the site for the program's clinic and office, set up a Diocesan Scholarship for nursing and midwifery students who usually work as volunteers for the program while awaiting the results of their board examinations. In 11 of the 12 parishes under the diocese where the program operates, the Parish Health Team works under the Service Commission of the church and is composed of the CHW, a medical professional from the parish and member of the parish service commission.

At the parish level, the local priest's involvement can range from full to passive support. An example of the first one would be a parish priest in Negros who made the initiative in contacting the program staff to set up a program in his parish and provided the staff with the needed facilities and contacts to start their work. He has remained concerned about the program and can be reached at any time by staff members for assistance.

Another parish priest in Negros who was, according to some CHWs, somewhat lukewarm in his support for the program actually possessed a good grasp of the needs of the program. His parish is the site of the parish clinic and herbal garden and the CHWs are free to use the convent for meetings and seminars. But,because the parish is a poor one, the priest says his support is limited to educating the people on the purpose of the program and endorsing solicitation letters of CHWs to raise transportation money. He explains that the parish health program stems from the church concept for total human development which encompasses not only the care of the soul but of the body as well. He is also aware that the program is considered subversive by some section of the community but he attributes this to a limited and traditional view of the church as concerned only with spiritual matters. He defends the program saying that when it traces the roots of ill health to the gap between the rich and the poor and the unequal distribution of wealth and power in the country, the program is merely stating a reality. What impresses him most about the program is the health services it has made accessible to the people and underscores this by relating the hundreds of patients who come for the monthly medical clinic. He himself calls on the CHWs to treat him for arthritis.

On the other hand, problems arise in areas where a parish priest's grasp of the program is limited to its service components. He may demand that staff members fill in a daily time record which is an impossibility as the staff members are usually making the round of the villages for organizing and training work. Or he may rechannel funds earmarked for the health program to other parish programs closer to his inclination like a catechetical program.

Aside from the support of the religious community, the support of the lay people for the program facilitates its continued growth. The support takes the form of active participation in health campaigns such as immunization drives, setting up of the village clinic or herbal garden and material and moral support for their health workers. In organized communities, this support is generally easy to generate as the organization complements the efforts of the CHWs in disseminating a particular activity usually ensuring a high rate of participation among the people. In unorganized communities, the program staff and health workers have to be resourceful in generating support from the people. One clinic in Negros was built from the funds donated by a religious congregation in exchange for the assistance rendered by the CHWs in the congregation's outreach program on child feeding. The herbal garden in this parish, though set up by the CHWs and some mothers, is maintained by school children during schooldays as part of the school's program. Another clinic was built from material and labor donation of the beneficiaries of the program. The Negros' main clinic was furnished by donations (a wall clock and cash for an electric fan) from well-off members of the community as well as the labor of farmer-beneficiaries of the program.

However, community support in unorganized communities or even communities with organizations that do not actually function can be inadequate especially in the areas of preventive health care such as sanitation drives or herbal preparation which can remain a purely CHW concern rather than a community wide undertaking. At the same time, inroads in changing traditional superstitious beliefs on the causes of ill health remain minimal as the basic grasp of CBHP orientation remains in the main limited to the CHWs.

Program Management

The program's streamlined structure where only a small number of staff members are based in Manila and the rest are distributed in the different program areas in the provinces serves the grassroots thrust of the health program.

The National Health Office as the over-all coordinator of the program is kept informed of the progress and problems of the areas through a system of reporting and consultations. Quarterly written reports are submitted by the diocesan health team to the national office detailing the progress of the work, the problems and recommendations. An annual report summarizing the work for the year is also a requirement. (See Appendix D for the guidelines used for this annual report.) The National Staff also schedules area visits to monitor and follow up personally the work at the diocesan level. An annual national health assembly attended by representatives from the areas and bi-annual interisland or subregional consultations are regular venues for discussing common problems and coming up with solutions. Community health workers at the parish level collectively prepare a written monthly report to the diocesan health staff. The report is a simple enumeration of the activities done for the month, the number of participants, the health worker's problems, needs and recommendations. (A sample monthly report of the CHWs in a parish in Negros for October 1988 contained such activities as a parish medical consultation, a session in Basic Health Skills training, herbal collection and preparation, monthly in- service meeting, a community health campaign for sanitation and the setting up of herbal garden and bible study session. They listed lack of finances and black propaganda as their problems and medical instruments as their needs. Finally, the report contained the financial statement for the month which said that P79.70 was spent for herbal preparation and ₱105.00 was the amount received from patients' donations.) Each CHW is also expected to fill and submit individual records of those she has assisted in the village or during parish medical consultations. (See Appendix E for a sample form used by the CHWs in Negros Occidental.) However, records taken during medical consultations where the CHWs work under the supervision of the program staff are more efficiently done than those taken by the CHWs in the villages. The CBHP in Isabela, seeing that this problem owes basically to the narrative requirements of the form which most CHWs find difficult to meet, has revised this so that the health workers need only to check most of the items.

A general assembly of all CHWs in a diocese is held once a year, traditionally during December so as to culminate with a Christmas party for the personnel of the health program. The annual assessment and planning for the coming year is made. Monthly program assessment and programming is made at all levels from the national to the parish.

Continuing staff development is a built-in component of program management and are based on skills assessment and job description of staff members. The National Health Office is responsible for the staff seminars at the national and diocesan levels while the diocesan program staff takes care of the needs of the parish program staff with the national office assisting in providing materials and resource persons. Special education may also be availed of by staff members. Some medical professionals in the staff, for example, have enrolled at the UP Institute of Public Health for special courses while a number of CHWs have attended training programs given by other non-governmental organizations. One interesting program of continuing education for CHWs is that of Isabela. CBHP

staff through the use of case studies of CHWs patient's records deepens the understanding of health workers of principles they have learned in previous trainings. In Negros Occidental, the monthly parish in-service training where all CHWs in the parish together with a program staff evaluates the work done for the month also includes discussions of current issues.

Record keeping and documentation of meetings, assessments, programs and communications appear to be consciously done both at the national and diocesan levels. It was generally easy to secure copies of relatively recent reports and training materials but there seems to be a problem in maintaining records of old but important files. For example, the national office does not have copies of several written evaluation of the three pilot areas made in 1976. Systematized financial statements of the years prior to 1985 are not available. There are also gaps in the records of important quantitative indicators of the program's growth such as the number of CBHPs set up through the years; the number of CHWs trained and the number of families served by the program. One reason for these gaps appear to be an RM policy mandating the destruction of records of over five years to give room to newer files.

Documentation of important assemblies and consultations are systematic but a conscious effort to ensure continuity by assessing previous recommendations and resolutions of a previous year to serve as basis for new plans is not clearly exerted. In much the same way, CHW reports and records are not clearly used as a potential source of improving training curricula or coming up with new ones. A possible reason for this is that administrative, training and service functions take up most of the time of the limited staff members leaving them little or no time for systematizing collected data to serve as basis for more concrete plans and actions.

Finances

The absence of comprehensive financial reports prior to 1985 limits this section to the audited financial statement of the RM CBHDP for the period from 1985 until the end of August 1988 and to interview with program staff members. Cash grants from Misereor for the period covering January 1, 1985 to August 31, 1988 reached almost P2.7 million and accounted for 62% of the operating funds of the RM CBHDP. (See Table 1.) Local counterpart in kind (office space, working time given up by CHWs to attend seminars, transportation expenses) with a cash equivalent of almost P1.6 million made up the balance.

Major expenditures went to personnel salaries and education and training costs where 86 % of the Misereor grant went. Fifty three percent (53%) paid for the salaries and medical benefits of an average 60 full time personnel of the program. Thirty three percent (33%) was used for the holding of training seminars. Around 15% was used for transportation and travel costs (7%) and for meetings and consultations (8%). The rest went to operating expenses and office equipment (8%). The total is over 100% because the program's deficit for that period reached over P300,000.

The P1.4 million from Misereor grants for personnel salaries was supplemented by P850,600 as local counterpart for a total of P2.3 million for the 42 months. With 60 personnel, this amount yields

an average monthly salary for each staff member of only P900.00. This is not even half of the legally mandated minimum wage in the country which is around P1,900 a month. Salary appropriation is incredibly low considering that almost half of the program staff are health professionals who can get higher pay outside the program.

Table 1. Financial Statement for Period from January 1, 1985 to August 31, 1988

Income	Cash Grant		Counterpart	Total
	P 2,693,137.72		PhP1,589,300.00	PhP 4,282,437.72
Expenses		% of Grant		
Personnel	1,415,821.60	53%	850,600.00	2,266,421.00
Education, Training, Seminars	893,089.00	33%	275,000.00	1,168,089.00
Meetings, Consultations, Evaluations	255,536.00	8%	64,700.00	290,236.00
Transportation and Travel	194,814.00	7%	300,000.00	494,814.00
Audio-visual & Educational Expenses	73,710.00	3%		73,710.00
Secretariat Expenses	134,365.00	5%	84,200.00	218,365.00
Furniture, Fixtures	90,904.00	3%		90,904.00
Referrals			15,000.00	15,000.00
TOTAL	3,028,239.00			
DEFICIT	335,102.00			

Members of the National Health Office reveal that the turnover of program staff is relatively high and it is difficult to hire new ones because of the substandard personnel salaries. For example, of the seven doctors who were CBHDP staff members in 1985, only two remain at present (1989. Three have decided to get higher paying jobs by working in hospitals or going abroad. The other two transferred to other health-related NGOs where the pay is higher. At present, the National Health Office is finding it difficult to hire a dentist as the starting salary asked by dentists they have interviewed is P3,600 and the office can offer only P2,500.

The other major outlay, that for education and training seminars totaled P1,169,000.00. Seventy six percent (76%) of this amount, or P893,000, came from Misereor while the rest (P275,000) was the local counterpart which is the total cash equivalent of the work days given up by CHWs computed at P25 per day, the average wage rate in the rural areas. Given an average of 20 trainings a year with an average total participant of 500, the training cost per person is about P650 which covers the food and accommodation for the four to five day duration of the training (including arrival and departure days).

Income deficiency or an excess of expenses over income for the reported period, according to the National Health Office, is not caused by program overspending. Rather it is due to the delay in the remittance of Misereor grants to the program. Technically, this amount cannot be considered as actual deficit because it would be covered by the delayed remittance. However, delayed remittances continue to this day. For the first six months of 1989, the National Health Office has to operate on borrowed money while awaiting the Misereor grant for that period. The cause of previous delays in remittances was attributed to questions raised by the donor agency regarding the program's financial statements. This was remedied with the hiring of an external auditing company to look over the financial accounts of the program starting in 1986. The current delay in the sending of funds to the program as far as the staff is concerned is due to the lapse of time between the approval by the Misereor department of the budget proposal of RM CBHDP and the actual release of the funds. A more efficient method of fund remittances from Misereor appears to be a necessity as the RM health staff has found no other means to generate local funds except by borrowing from other institutions.

Staff members of health programs in the dioceses directly under the RM CBHDP are paid from the latter's funds while those programs turned over to the Diocese are supported by diocesan funds. The Isabela health program which has been directly managed by the Diocese since 1977 has standardized staff salaries and benefits. The basic salary is pegged at P1,200 a month. On top of this, amounts based on the job description, called the responsibility premium, and on the length of service are added.

Staff members are also covered by social insurance and medicare and receive the 13th month pay. Because the Isabela diocesan health program has its own facilities and ground, staff members enjoy free housing in the staff cottage and receive rice and vegetable rations from a small farm cultivated around the clinic. At present, the nurse coordinator of the Isabela health program receives a monthly salary of P2,500.

The Negros health staff has yet to attain this level of standardization. Staff salaries there range from P1,000 for the newest member of the staff (a former CHW) to P3,000 for the doctor-coor

dinator. A staff member who has been with the program since 1984 receives only P1,300 after almost five years of service. The only fringe benefits that the staff enjoys is the 13th month pay and an annual two-week vacation with pay. While the National Health Office would like to set a standard rate of P2,000 starting salary for all program personnel regardless of area of assignment, they have been unable to do this because of objections from church officials who feel this would place at a disadvantage other paid church workers outside of the health program. Opposition to higher pay for the health staff also come from RM sisters who feel that as RM workers, the lay members of the staff should be satisfied with current rates. However, consideration needs to be given to lay workers given the fact that religious members of RM receive from their congregation in terms of housing and/or medical assistance. On the other hand, in a recent interview, one of the RM sisters who started the program pointed out the need to make the salaries of RM health workers competitive with other non-governmental institutions so as to reduce the loss of staff members.

Funds for the RM CBHDP are allocated by the General Assembly. It may be recalled that the General Assembly meets every two years during which a program of action is prepared, which is itself based on the program of action submitted by each of the four RM programs (CBHDP, Rural Integration, Peasant Services, and Research and Documentation). As resources are always limited and insufficient to meet all the requests, each of the four programs has to lobby for and compete with each other for funds. And, although one's program of action may gain the approval of the General Assembly, it does not assure the program that funds for it are forthcoming since RM funds are also dependent on grants from funding agencies.

Each of the four Program's program of action is prepared after consultations with the various levels of the organization which make requests based on their needs and priorities. The program of action of the CBHDP, for example, is based on the requirements of the National Health Office itself, with its two service desks, and the fifteen Diocesan Health Teams. Funds to the latter are released quarterly based on their 3-month budget requirements. On the other hand, National Health Office prepares a monthly budget and funds are released to it accordingly.

Each level in the organizational system has a finance officer, or its equivalent, who ensures that funds are disbursed properly and who, therefore, acts as the unit's internal auditor. Disbursements, for example, require the signature of two members of the Executive Committee or its equivalent. Periodic financial reports are submitted and an annual audit is conducted by an external auditing firm.

Effects of the Armed Conflict on the Program

The RM CBHDP's problems with military harassment started in 1980 when the health program started to be involved in non-health issues affecting the peasantry such as the land problem. The Isabela health program, began in 1975, started to be harassed in 1980 during the height of the farmers' struggle against evictions from two large haciendas in that province. Health workers trying

to set up the program among national minorities in the interior villages in the boundary of Isabela and Ifugao were likewise harassed and were arrested. They were released only when the tribesmen themselves petitioned the military authorities to free them.

Militarization, the government's response to the armed insurgency demanding basic structural reforms in the country, has proven detrimental to RM CBHDP's efforts to improve the health of the rural population. Documented cases of human rights violations affecting health programs and personnel for January 1987 to June 1988 issued by an organization of health professionals listed 53 cases ranging from massacres, summary executions, illegal arrests and detention to burning of houses in program areas involving at least 90 victims. These violations have led to the stoppage of health program operations in 267 villages and their disruption in 305 others. Community health workers facing constant threats and harassments have opted to resign (101) or become inactive (259) while over 350 others who were still undergoing training dropped out of the program. Reported perpetrators are usually members of the Armed Forces of the Philippines or of paramilitary and vigilante groups which have proliferated in the countryside since President Corazon Aquino's formal declaration of total war against insurgency in 1987. While these cases also involve programs and personnel of other health agencies, majority of these directly affected the RM CBHDP network.

The health program's vulnerability to military attacks appears to lie in that fact that committed medical and non- medical personnel whose work takes them to remote rural areas where the health program is most needed are considered communists or communist sympathizers by government personnel. Furthermore, the program's refusal to limit itself to palliatives and its consistent advocacy of total social development as the key to the solution of the health problems of the country if done in an open and legitimate manner opens it to vicious attacks from the country's political and economic elite who could not be bothered by the continuing deterioration of the health situation of the population and would prefer to keep the people in a state of dependency.

In spite of the increased risks that they face, the RM CBHDP personnel in general remains highly committed to the propagation and implementation of the program as evidenced by the continued operations and growth of health services in many areas. What has been greatly affected by continued military operations and harassments of program areas are the mobilization of volunteer health professionals to assist the program and the higher incidence of CHW drop outs. Also, new services such as health assistance in relief and rehabilitation programs brought by the forced relocation of villagers and disaster preparedness (for man made disasters such as bombings and burnings) have to be implemented as a response to the new problems brought about by intensifying militarization adding to the work of an already overburdened program staff.

Some Observations

The RM health program, 12 years after its inception, has gone a long way in its objective of setting up an alternative health care delivery system that is people oriented and is linked to the goal of

social development. Quantitatively, this is reflected in the growth in the number of areas in the country where the health program operates: from 27 to 432 villages, from 15 to 79 towns and from 3 to 15 dioceses; the greater number of health professionals directly involved with the program and to the number of community health workers providing preventive and basic curative cure at the village level.

The program has been responsible for propagating and popularizing the use of alternative treatment methods particularly herbal medicine and acupressure lessening to a certain extent the demand on expensive western medicine. It has also made possible accessible and low cost health services to villagers through the services of the CHWs and through parish medical consultations. It has become an intermediary between villagers living in otherwise unserviced rural areas and government health workers who are mainly based in the town centers through CBHP's role in immunization and TB control. CBHP's approach to the health problems of the country relating it to the wider social problems of economic and political inequality has contributed to the task of national consciousness raising, particularly among the health sector where it has helped develop health professionals committed to the goal of social transformation. Leaders for health and non-health organizations have also emerged from among the village health workers.

The study reveals that after over a decade of operation, the RM CBHDP must now address a number of issues to ensure its growth and continuity. These issues relate mainly to the task of strengthening managerial and technical capability within the program. Considering that much of previous years were really spent at building the institutional/organizational mechanisms and linkages for program implementation, training program staff and CHWs, and for piloting and expanding program services, one cannot reasonably expect the RM CBHDP to have also acquired all the needed capability of planning, managing, monitoring, and evaluating their program activities and operations. RM CBHDP's past experience, however, now offers program staff and participants the opportunity to review earlier activities and systematize the manner in which the program will proceed.

First, we should probably point out that this initial attempt at evaluating the growth and role of CBHP has been hampered by the irregular data recording of important components of the program and this deficiency, if not corrected, will continue to hamper future evaluations. For lack of data, the present study cannot quantify the number of CBHPs established through the years and their breakdown in terms of the number turned over to dioceses, the number and reasons of those that have closed down or fizzled out, and the number of those still operating under RM sponsorship. Neither can the study approximate a "cost-benefit" analysis of the program, considering the discontinuity of program financial reports and the fact that program proponents and donor agencies may not have been conscious of the need for a cost-benefit assessment at some later date. Hence, they did not build into the program the data requirements for such an analysis. Consequently, the study can only describe in general terms the growth, activities and accomplishments of the program, although the financial reports available since 1985 do not indicate wastage in program funds. Program salaries remain below market levels, while training costs for health workers are modest, and the volunteer time of program personnel and particularly the CHWs, would easily exceed local counterpart estimates to the program if these were fully costed. Still, the importance of regular reporting on activities, finances and results (or accomplishments) must be emphasized if RM

CBHDP wishes to better assess the effectiveness of its program strategies, and the efficiency with which it allocates and use its resources.

Second, the program may also benefit from a comprehensive study of CHWs to arrive at a profile of their socioeconomic backgrounds, health skills levels, and the number of years they stay with the program. This kind of "taking stock" activity can help the program refine its strategies for CHW recruitment, training and development. It can also suggest ways of dealing with the high rate of turn-over among CHWs (20% nationwide but reaching as high as 50% in some areas). The twin problems of military harassment and economic difficulties have been cited as the major reasons for this.

CHW organizations have therefore been formed to partly respond to this turn-over, but this remains far from adequate. While a CHW organization was set up in Isabela in 1984, CHW attrition remains high in that province. Value formation and further developing the commitment of health workers may temporarily assuage the problem, although concrete steps to improve the economic situation of health workers must be taken likewise. At this point, therefore, RM CBHDP might consider setting up a CHW desk to concentrate on CHW training, development and retention needs.

Third, RM CBHDP may also wish to reassess its involvement in direct organizing work which are not directly health related. Historically, the CBHP has served as an entry point for organizing during its early years when people's organizations were practically non-existent. In the early part of the 1980s, the rapid growth of people's organizations led to a reformulation of CBHP's role as a support program for people's organizations. But in recent years, CBHP has again resumed direct organizing activity owing to intense militarization which in turn has caused the dissolution or inactivity of a number of people's organizations. Hence, current program focus remains at both organizing and health training and services since community support for health programs is feasible only with sustained and viable people's organizations. This double emphasis, however, results in overstretching the capabilities of the staff and hinders the advance of health programs, trainings and services. One possible option is for RM CBHDP to concentrate on linking with established people's organizations particularly peasant and women's associations. This will allow the agency to focus on meeting the health needs of communities through improved training and services rather than divide its efforts between direct organizing and health training and service delivery.

Finally, given the limited number of personnel in the national office of RM CBHDP, improved management methods may enable it to better balance its over-all supervisory functions and its assistance to particular local programs. Three suggestions are forwarded:

1) More realistic programming in terms of setting up new health programs or answering requests to assist health programs of other church groups and the need to consolidate existing network of RM. Interviews with staff members revealed that they find it difficult to turn down requests of church people to help set up new programs.

2) Taking into account the over all needs of the national health program while providing specific guidance to a program at the local level. A member of the National Health Office is sometimes sent to an area for a period of one to three months to directly assist the local staff in training and

management. The experience in that area can be documented and can be popularized nationwide. In the same manner, new and effective methods developed by the local program areas such as the reported clinical case method used in CHW training in Isabela can be studied in depth by a member of the national staff, documented and popularized.

3) Emphasis on consolidating and systematizing records and reports should be done to provide the basis of new plans and the future monitoring and evaluation of the program. The known exigencies of Philippine political and economic conditions have honed the CBHP's ability to sustain program operations under changing environments and sometimes under inhospitable conditions. It is perhaps time that RM CBHDP and its partner agencies look into the possibilities of bringing in technical assistance to upgrade internal managerial and administrative capacities in running the program. Among such areas for assistance are planning and programming and the institution of integrated recording, reporting and monitoring procedures that can assure program continuity even as program personnel and administration may change.

Appendix A: Sources of Information/Data for Case Study

1. RM CBHDP Progress Report for 1986-87
2. RM CBHDP Progress Report for Period January to December 1988
3. Documentation of the Proceedings of RM National Health Assembly 1986, 1987, and 1988
4. Audited Financial Statements of RM CBHDP
5. Evaluation of RM CBHDP from 1975 to 1985
6. Interviews with
   - National Health Office Coordinator
   - Head, Services Desk, RM CBHDP
   - Three RM Sisters who pioneered the program
   - The Program Staff Members, RM CBHDP Negros Occidental
   - 5 CHWs of Negros Occidental
   - One Former CHW of Isabela, now an officer of a national peasant women's organization
   - Parish Priest in Negros Occidental
7. RM CBHDP Report for 1985 National Convention of RMP

Appendix B: Training Curricula of RM CBHDP

A. Basic Health Orientation Seminar (BHOS)

1. Structural Analysis of Health
2. Economic, Cultural and Political Aspects
3. National Situationer
4. What is CBHP?
5. Principles, Methodology and Implementation
6. Health and Community Organizing
7. Role of the Community

B. Basic Health Skills Training (BHST)

Body Functions

Body Normals: Temperature, Pulse Rate, Blood Pressure

Transmission of Diseases

Common Illnesses: Causes, Signs and Symptoms, Treatment

Introduction to Herbal Medicine

Why Use Herbal Medicine

The Drug Industry

Collection and Preparation of Medicinal Herbs

Common Childhood Diseases

Evaluation

C. Advanced Health Skills Training

Maternal and Child Health

History and Physical Examination

Upper Respiratory Diseases

Common Diseases (By System)

Nursing Procedures

Nursing Care (Injections, IV Insertions)

Acupuncture

Laboratory Examination

Minor Surgical Procedure

D. Special Skills Training (Different Modules)

Program Management

CO Skills

Teaching-Learning Skills

Oriental Medicine

Minor Surgery

Differential Diagnosis

Source: Latest RM CBHDP Training Guidelines

Appendix C: Topic Outlines of the Training Curricula of the RM CBHDP in Negros Occidental

I. BASIC ORIENTATION SEMINAR

II. BASIC HEALTH SKILLS TRAINING (BHST)

A. Concept of health and disease

B. Principles of disease causation

C. Principles of disease prevention

1. Environmental sanitation

2. Safe water supply

3. Personal hygiene

4. Dental hygiene

5. Accident prevention

6. Nutrition

7. Immunization

8. Mental health

D. Basic diagnosis

1. Anatomy and physiology

2. History and physical exam

3. Common signs and symptoms

4. Common diseases

5. Record keeping

E. Treatment

1. Home care of the sick

2. Traditional medicine

a. Oriental diagnosis

b. Herbal medicines

c. Pressure treatment

d. Moxibustion

e. Ventusa

3. Rational drug use

F. First aid

G. Maternal and child health I

1. Sex education

2. Pre and post natal care

3. Care of the newborn (immediate)

4. Responsible parenthood

III. ADVANCED HEALTH SKILLS TRAINING (AHST)

1. Advanced nutrition

2. Trauma management

3. Management of mental illness

4. Maternal and child health II (incl. intra-natal care)

5. Management of epidemics

6. Laboratory procedures

7. Disaster management

8. Acupuncture

9. Minor surgery

10. Dentistry

11. Differential diagnosis

12. Pharmacotherapeutics

13. Under-five clinic

IV. SPECIAL SKILLS TRAINING (SST)

1. Conduct of health campaigns and education

2. Community organizing

Appendix D: RM CBHDP Guidelines for Annual Reporting

I. Burning Issues in the Region

II. Program Implementation Updates

1. Area Profile
2. Profile of CHWs
3. Profile of Program Staff
4. Status of Organizing Work: CHW, Community, Health Professionals
5. Status Report on Coordination Work
   - program profile about programs within the RM network
   - list of church-based health services in the program area and level of coordination with them
   - status report on coordination with government offices
6. Brief Status Report on the stresses and plans and problems, needs in terms of training, services, health campaigns, program management

III. Problems Encountered in the Over-All Program Implementation

IV. Recommendations/Projections

The Council for Primary Health Care:

A Case Study

by

Ma. Asuncion Benitez

Introduction

The establishment and growth of the Council for Primary Health Care (CPHC) has been closely linked with the development of community-based health programs (CBHPs) in the Philippines. Taking off from the initial efforts of the nuns of the Rural Missionaries in the early 1970s to set up health programs anchored on the community-based method, many other groups and organizations have since adopted the CBHP approach and utilized this to improve health care delivery in the country's most neglected communities. However, many of the CBHP initiatives were autonomous and locally-based, and hence, limited in the their scope and operations. There was minimal contact and even less coordination among groups engaged in CBHP work, except perhaps those operating in Catholic parishes sponsored by the Rural Missionaries (RM) and those under the National Council of Churches in the Philippines (NCCP).

As more and more CBHPs were formed, program advocates perceived a need to share experiences, expertise, and assessments of how they could improve and advance in their own local efforts. In 1978, the First National Consultation of Health Professionals working in CBHPs was held in Cebu under the RM's auspices. Among the Consultation's concrete recommendations was the creation of a "national body to monitor the developments of the different CBHP areas and to serve as a channel through which services and assistance could be extended to them." This national consensus of setting up a central coordinating office for CBHPs was considered the most logical response to the growing challenges posed to health professionals after almost half a decade of implementing the community-based health approach to basic health care. Thus, the Council for Primary Health Care was created. On May 22, 1980, the CPHC was officially registered at the Securities and Exchange Commission as a private, non-stock, non-profit organization whose fundamental aim is "to actively respond to the basic health needs and improve the health conditions of the people."

Philosophy and Objectives

The CPHC philosophy is likewise closely connected with that of the CBHPs. The Council adopts an activist, holistic approach in dealing with health problems. It believes that health is related to the objective conditions of the country and that the underlying causes of health problems are deeply rooted in the social, economic, and political structures of that society. It envisions the way to lasting good health for the people, especially the poorest and most exploited ones, as lying in the radical restructuring of unjust systems, toward a wide-ranging social transformation. Thus, it may be admitted that health programs, even the CBHP kind, are not <u>the</u> solution to health problems, although their value in initiating and contributing to the process of social change is undeniable.

The CPHC also firmly believes in the CBHP approach characterized by its bias towards the poor, particularly in the rural areas; its deviation from the dole-out orientation of most health programs; its rejection of the elitist, doctor-dependent concept of health care; and, more importantly, its promotion of the participatory method in decision-making for community action which, in this case, encourages people to take responsibility for their own health. The CPHC further believes that, like

CBHPs, it has a role to play in raising people's critical awareness and in the promotion of local initiative, leadership, and self-reliance.

To interpret this comprehensive philosophy, the CPHC has set for itself the following objectives:

1) To initiate improvements in the existing health conditions of the country by adopting an approach involving full community participation in primary health care (PHC). According to the definition of the World Health Organization (WHO), which CPHC fully adheres to, PHC is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation, and at a cost that the community and country can afford.

2) To build a base for a PHC system by coordinating, monitoring, servicing and assisting health programs and other community endeavors for total human development.

3) To influence government policies and decisions concerning PHC delivery systems in the Philippines.

History

The CPHC's history may be divided into four periods based on the Council's evolving strategy and capability for implementing its multiple functions. The first period, covering 1980-1982, was one of basic orientation for its staff and the Council itself, initiating activities continually while at the same time discovering the difficulties and limitations. The second period, from 1983-1985, was that of self-definition by CPHC of its role vis-a-vis CBHPs, and of gradual expansion. The years 1986-1988 comprise the period of greater self-confidence on the part of the Council, and therefore of rapid growth and expansion. The fourth period covers the present year, 1989, a period of transition for the Council as it prepares to merge with other organizations for form a new national CBHP body.

1980-1982

The initial years of CPHC constituted a period of orientation and institution- and capability-building. Although the CPHC incorporators were themselves well-grounded in CBHP work, many of the staff were new to the community-based approach and the principles of primary health care. Even if CPHC could have hired more experienced people, this would have meant pulling out local CBHP workers from their areas, and programs would have suffered as a result. Hence, for the staff it was a time of "groping" and insecurity (a staff member described it as the "Dark Ages" of CPHC). As a result, many of the policies the Council formulated then were generally for its internal operations and training. CPHC's focus of concern was directed at building and strengthening its Secretariats, while trying to respond to the immediate needs and requests of various agencies.

As part of developing early linkages, CPHC helped form an Inter-Agency Committee (IAC) with RM, Urban Missionaries (UM), National Ecumenical Health Concerns Committee (NEHCC) of the NCCP, Alay Kapwa Kilusang Pangkalusugan (AKAP), and the Society for the Advancement of Traditional Medicine (SATMED). (SATMED is now defunct.) The IAC was an organizational structure that provided its members with a venue for discussion and collaboration in joint activities, without compromising or straining the identities of each group, none of whom, at that time, seemed ready to be subsumed under CPHC. On the other hand, CPHC was always very conscious of not impinging or threatening the independence of other autonomously organized agencies. In fact, a proviso in its incorporation papers, stating that "it would formulate policies and decisions only for its internal operations," was meant to ensure that its existence would not discourage the initiatives of individual programs.

During its first years of operation, the Council spent considerable efforts in establishing its own project areas, as stipulated by its contract with the funding agency. This implied the recruitment and preparation of field staff, careful selection of areas (i.e., ensuring that no other program existed there to avoid duplication), and undertaking the organizational, educational and health training activities called for by a CBHP. This direct participation of CPHC in managing health programs served as valuable firsthand experience and training for its staff, and for the health professionals, students, and other visitors it brought to the areas for "exposure." The project areas, likewise, served as testing ground for new training methodologies and research findings. However, in concentrating its efforts on establishing new CBHP areas (five pilot areas in all), as well as in servicing the immediate program needs of other organizations, CPHC became remiss in attending to its other important function as a central coordinating body.

The year 1981 was an important one because the Council participated in the National CBHP Staff Conference to assess the development of CBHPs after six years and to come up with a national strategy. Also in that year, CPHC suffered from lack of funding due to delayed grant transactions. As a result, many staffers were laid off and only a skeletal staff was maintained. Furthermore, pointed reminders came from the funding agency about CPHC's failure to fully exercise its coordinating function as evidenced by the existence of an Inter-Agency Committee that appeared to duplicate that role. Eventually, the IAC was set aside by consensus of its members (although it would resurface sometime in the mid-1980s), in a move that gave CPHC the chance to implement its coordinating function. In turn, it was decided to expand the Council's Board of Directors to include representatives from the other former IAC organizations for continued contact.

In the meantime, a comprehensive program assessment of CPHC in 1981 recommended the Council to streamline and prioritize its areas of concern. It was noted that the scope of its functions in the original project proposal was too extensive and that CPHC could not realistically fulfill all of them at the same time, considering, among other things, its serious resource constraints (e.g., staff, funds). Thus, the Council decided to focus on its main tasks of coordination and developing linkages through the promotion of program strategies that would strengthen CBHPs and the health care system in general. Concretely, this latter meant carrying out direct services such as training, education, research, publication, and information dissemination. CPHC also decided to relieve itself of the task of handling CBHPs directly, by starting the phase out of its five pilot areas and

turning them over to other CBHP organizations or straight to the communities after programs had achieved a certain degree of self- sufficiency.

1983-1985

The second period marks a clearer definition and delineation of CPHC's role vis-a-vis CBHPs, as spelled out by the new directions decided in its 1983 Board meeting. With an expanded Board, the directors were able to articulate the common perception of CPHC's tasks. These are: (1) coordinating and assisting agencies, programs and groups committed to promoting the community-based approach to PHC; (2) influencing other non- governmental health programs to adopt the community-based approach to PHC; (3) influencing policy-making and implementation of PHC by government bodies at different levels (municipal, provincial, regional, national); (4) developing the understanding and support for the community-based approach to PHC by local and international groups/agencies; (5) drawing health professionals and students to PHC as a people oriented and a community-based program; and (6) initiating and promoting special projects relating to health care for previously unreached sectors of the population.

In addition, the Board felt the need to clarify the definition of "authentic CBHPs" engaged in "primary health care," as the government and other traditional health programs had also started to employ such terms. More importantly, the Board clearly defined the coordinating functions of the Council, a move that should have been undertaken much earlier. These functions included: (1) monitoring developments in the theory and practice of CBHPs; (2) facilitating in the sharing of experiences and skills among grassroots communities and professionals involved in CBHP; (3) popularizing nationwide the lessons learned from CBHPs; (4) initiating consultations and conferences, especially those national in scope, to evaluate CBHPs; (5) doing critical studies on developments in the health field (especially in the promotion of PHC) in order to assist CBHPs to take a principled and well- informed stand regarding such developments. Furthermore, CPHC was strongly urged to exert greater influence on other health programs which have yet to become aware or be convinced of the CBHP approach. And finally, the Council was also encouraged to assert its central leading role among non-governmental organizations (NGOs) in PHC work, in order to be in a better position to influence policies and programs emanating from such offices as the Department of Health (DOH), WHO, and other established institutions.

With these guidelines in place, CPHC set out to streamline its staff functions and activities for greater efficiency. However, positive results could not be immediately effected due to both internal and external factors. Internally, there was a general lack of focus and prioritization in doing tasks. Even if the five project areas had been completely phased out at the start of this period, many other plans were left unaccomplished by the different Secretariats perhaps because there were just too many projects to begin with. There was a need for a more efficient and organized system for the staff to balance work, meet deadlines, etc. Externally, the Council's work in recruiting, training, developing, and deploying personnel for CBHPs was hampered, particularly in 1983, by the worsening general economic situation and the militarization of certain areas in the country.

Among the notable gains of the period was the inception of the Factory-Based Primary Health Care Program (FBPHCP) in 1983, in line with CPHC's task of initiating and promoting special projects on health where these are needed and none existed before. It was a pioneering effort that started out slowly due mainly to strong repression of union leaders, some of whom were also the ones being trained as health workers, but the program went into full swing by 1984. The aim of the project was to respond to the growing health needs of workers in the urban centers following the CBHP philosophy. Starting with an initial staff of two who implemented the various components of training, research, organizing and publications (the project had its own separate funding), the program expanded its areas of operation to many more factories in Metro Manila and Baguio. Basically functioning through unions or organized worker's groups, FBPHCP formed Health and Safety Committees from where they developed trainors. These were coordinated by factory and by industry (e.g., textile, electronics, metal and allied industries). They published a Health and Worker's Bulletin which mainly addressed occupational health problems. By 1987, it was found that the program could stand on its own, so CPHC prepared for the phase out of its supervision. In 1988, the FBPHCP became the Institute for Occupational Health and Safety Development (IOHSAD).

Another important occurrence during the period was the introduction in April-May 1983 of the Summer Exposure Program (SEP), a joint project of the CPHC, NEHCC-NCCP, the Philippine Nursing Students Association, and the Philippine Alliance of Medical Student Councils. The program consisted of two parts: one week of intensive orientation and skills training followed by two weeks of barrio exposure. A total of 29 social work, medical and nursing students in two batches attended the seminars, though only 13 stayed on for the barrio experience. This innovative educational program aimed to expose the participants to rural health conditions and the CBHP alternative approach, and from there, develop a group of young committed health professionals who can share their knowledge and skills with the communities, and be encouraged to work in CBHPs after finishing their studies. The success of the program may be seen in the presence today of some of the original exposurees as staff members of CBHPs. Experience had shown that it was harder to recruit people who were already professionals, because they preferred to get good- paying jobs. Not long after formation, the SEP became the Philippine Youth Health Program (PYHP), still active today in CBHP activities, but as an independent organization from the CPHC and the other original sponsoring groups. Still another gain during these years was in publications, where there was a 35% increase in regular subscriptions to the CPHC newsletter (Tambalan), a sign perhaps of CPHC's increasing popularity and recognition in the health field. Despite this gain, however, many of the issues and other materials were still delayed in coming out. This was mostly due to the overlapping activities of the staff, or perhaps CPHC's actual lack of personnel. During the second half of the period, many more area visits were carried out, giving the Council a broad overview of the current situation of CBHPs in the country. Nevertheless, it was admitted that there was a need for more comprehensive preparations by the staff prior to the visits, as well as a more systematic collation and evaluation of reports after their trips. Follow-up visits were also suggested.

In the area of contact building, CPHC increased its participation in campaigns organized by multi-sectoral groups in Manila and in its linkages abroad. It started to establish its own network of mostly non-sectarian CBHPs. The Council also began to emphasize its role by sponsoring, conducting and documenting more CBHP conferences, consultations and activities in the national, regional and local levels. For example, in 1984 CPHC sponsored a major national consultation

called "Towards Participatory Evaluation of CBHPs in the Philippines." Two significant accomplishments of this meeting were the unification of the common understanding of CBHP's history and objectives, and the creation of a standard evaluation guide for the use of CBHPs in their program assessments. Other regional meetings that CPHC co-sponsored were the Negros-wide CBHP Conference and Luzon-wide CBHP Assembly (LUWA), both in 1985. Their purpose was to bring together the different NGO health programs in these areas to discuss the current status, level of resources of each, and to come up with concrete steps on how to facilitate health training and services among each one. A concrete result of the LUWA was CPHC's being assigned the responsibility for providing guidance and following up the implementation of plans set by the Luzon- wide coordinating body. On the whole, although CPHC's coordinating role had been better clarified to itself as well as to other CBHP agencies during this period, there was still room to improve and maximize its capacity for coordination. This stage in the Council's development could perhaps be classified as that of gradual contact building and cautious expansion.

1986-1988

This period may be considered the most productive in CPHC's history, principally because of two reasons external and internal to the Council. Firstly, due to the national events in 1986 marking the end of dictatorial rule under President Marcos and the start of the Aquino administration, there was a notable change in the political atmosphere that brought about the so- called "greater democratic space," especially at the beginning of the period. This meant that CPHC and most NGOs for that matter were able to operate more freely in holding consultations, visiting project areas, and disseminating information to the public. Secondly, because of CPHC's clearer understanding of its functions as a central coordinating body, added to the CBHP's increasing acceptance of it as such, the Council was able to grow and expand more rapidly during these years.

Using to full advantage the relative freedom to organize, CPHC worked to set up new structures within and outside the health sector. The Council served in the organizational committee of the Luzon-wide CBHP Consortium, where 31 CBHPs met to share and identify common concerns, and to create a body that would help meet the growing needs of CBHPs in Luzon. The Council gave active support in training, program visits, and regional consultations to the consortium, which unfortunately suffered from lack of personnel in 1987 and up to today seems to be inactive or abandoned, even as there is a lot of CBHP activity in the Luzon subregional and provincial levels.

Likewise in 1986, CPHC was active in the formation of the Visayas-wide Coordinating Body, which was established by 22 CBHPs in the Visayas through the assistance of the RM Community-Based Health Development Program (RM-CBHDP), the NEHCC-NCCP, and TEACH- Cebu. Because of some communication problems and difficulties caused by the region's peculiar geographical features, the body was still not fully functional in 1987. Today, a regional body called Community Action for Training in Community Health (CATCH) coordinates CBHPs in the Visayas. The Council deals with CATCH directly. With regard to Mindanao, most CBHPs are coordinated by the Community-Based Health Services (CBHS-Mindanao), with whom CPHC has contact. The Council, moreover, maintains linkages with the mostly non-sectarian programs outside of the CBHS network.

In addition, in 1986 the Special Projects Desk, through its Urban PHC Project/Program, organized and conducted two activities. These were the First National Consultation among NGO-Urban CBHPs and the Second National Consultation among NGO-GO Urban CBHPs.

It was also at this time when the CPHC began active consultations with government agencies, namely, the Department of Health (DOH) and the National Economic and Development Authority (NEDA), as well as the international agency UNICEF. This resulted in DOH's official endorsement of CPHC as an NGO working in health concerns. CPHC subsequently became involved in the Task Force of the Rural Health Practice Program (RHPP) for which its staff members gave orientation seminars to RHPP volunteers and took charge of fielding the volunteers to CBHP areas. It also participated in organizing a Regional GO-NGO body that was responsible for overseeing RHPP work and primary health care activities such as the anti-TB program.

This involvement of CPHC with DOH facilitated the coordination of local CBHPs with their counterparts from the government agency. However, it experienced delays in program implementation owing to overly bureaucatic procedures particularly at the higher levels of the government organization. Local CBHP implementors viewed government health personnel as official "watch dogs" owing to DOH's requirement of military endorsement prior to initiating projects in the CBHP areas. However, what was supposed to be a sustained GO-NGO partnership of sharing ideas and expertise degenerated into a situation where CPHC trainors merely became contracted resource persons for RHPP volunteers.

A major breakthrough in CPHC's coordinating role was its sponsorship and funding of the the Consultation of Major CBHPs in 1987, in cooperation with RM-CBHDP, the Philippine Youth Health Program (PYHP), and NEHCC. Twenty-five major CBHP representatives met to assess CBHP work, giving a comprehensive view of the Philippine CBHP situation. The significance of this meeting, among other things, was in the growing recognition of CPHC as the leading coordinating body for CBHPs. Many other regional, subregional, and local program conferences were held, not to mention the national consultation on training and on research and documentation, where CPHC continually played an active role. The Council was also requested to carry out numerous evaluations of regional programs as well as of CBHP agencies, reaffirming CPHC's increasing importance. In November 1988, CPHC again participated in the National CBHP Staff Conference composed of representatives from national and regional CBHP institutions. The Conference assessed CBHP work in the last four years, and came up with a unified understanding of CBHP philosophy, objectives, components, and methods. Another noteworthy accomplishment of the Council during this period was the vast extension of its contacts and linkages achieved through greater public exposure (e.g., speaking engagements, wider circulation of its publications); through collaboration in some activities with the government, multisectoral and national service organizations; through the hosting of many foreign visitors (including foreign government representatives); and through the participation of CPHC staff in international conferences. (For a list of CPHC's network linkages, see Appendix A.) Unfortunately, these opportunities were not maximized to promote and solicit support for CPHC's other major activities. Nevertheless, the whole period may be characterized as one of rapid expansion and growth for the Council.

1989

The year 1989 may be classified as a transitional period for the CPHC. It marks the stage when the Council's functions and activities may clearly be divided into two: those meant to wind up all unfinished assignments and projects started under CPHC, and those designed for the imminent establishment of the new national CBHP organization to be composed of CPHC and the health desks of UM and RM. The activities in the first division include finishing all reports (particularly the annotated proceedings of the 1988 National CBHP Staff Conference); completing all unfinished business assigned to the three Secretariats; conducting inventories for all documents, materials, supplies, etc. in the Council; and generally continuing to respond to short-term requests from the CBHPs for the Council's services. Along with this first set of activities was the task of providing assistance to the Program Impact Evaluation of CPHC, RM-CBHDP and CBHS. Aside from serving as a center of communications for this evaluation and providing staff to conduct household surveys in two barrios in Pampanga, CPHC also accommodated interview and field visit requests from this evaluator.

Among the second division of activities, the Council is streamlining all its projects and operations in anticipation of CPHC's merging with the other two organizations supposedly scheduled for September 1989, as was decided in a national consultation held in December 1988. The Council will also assist in the organizational preparations for the new body by way of giving its input in the documents to be drawn up (e.g., project proposals, organizational structures), attending consultation meetings, etc. The period can, thus, be characterized by the dual role of CPHC: on one hand, finishing up its work to leave a clear decade's contribution that it can be proud of, and on the other, preparing for a new and improved identity that is better equipped to face up to greater challenges of promoting CBHP.

Organizational Structure and Functions

The organizational structure of CPHC did not change substantially over the years, as may be seen by comparing its organizational charts in 1980 and 1988 (see Charts). Perhaps the only major change was in 1983 when the Council fully phased out from its five pilot project areas, and thus eliminated that component from its structure. What has undergone change in CPHC are the specific functions and tasks of its various components, increasing mainly in response to the greater demands placed on the organization.

Functionally, CPHC is divided into four Secretariats: Executive, Training, Research, and Communications. The Executive Secretariat (formerly Direction and Coordination) is composed of the Executive Director, Administrative Officer, and the three Coordinators for Training, Research and Communications. (A fourth Coordinator for Special Projects was added in 1983-88.) They meet once a month to report on each department's activities and problems, as well as to coordinate functions for CBHP service requests. They implement decisions emanating from the Board of

Directors or the Executive Committee. It was only in 1983-84 that the Coordinators began to play a more active role in the Council's administration. Before that, each Coordinator worked only on his/her individual tasks, thus there was little congruence in CPHC activities. Now, Coordinators submit regular assessment reports to the Executive Director on their Secretariat's activities every six months, based on the day-to- day entries that they make in their log books. In the case of the

Chart 1. CPHC Organizational Chart, 1980-1983

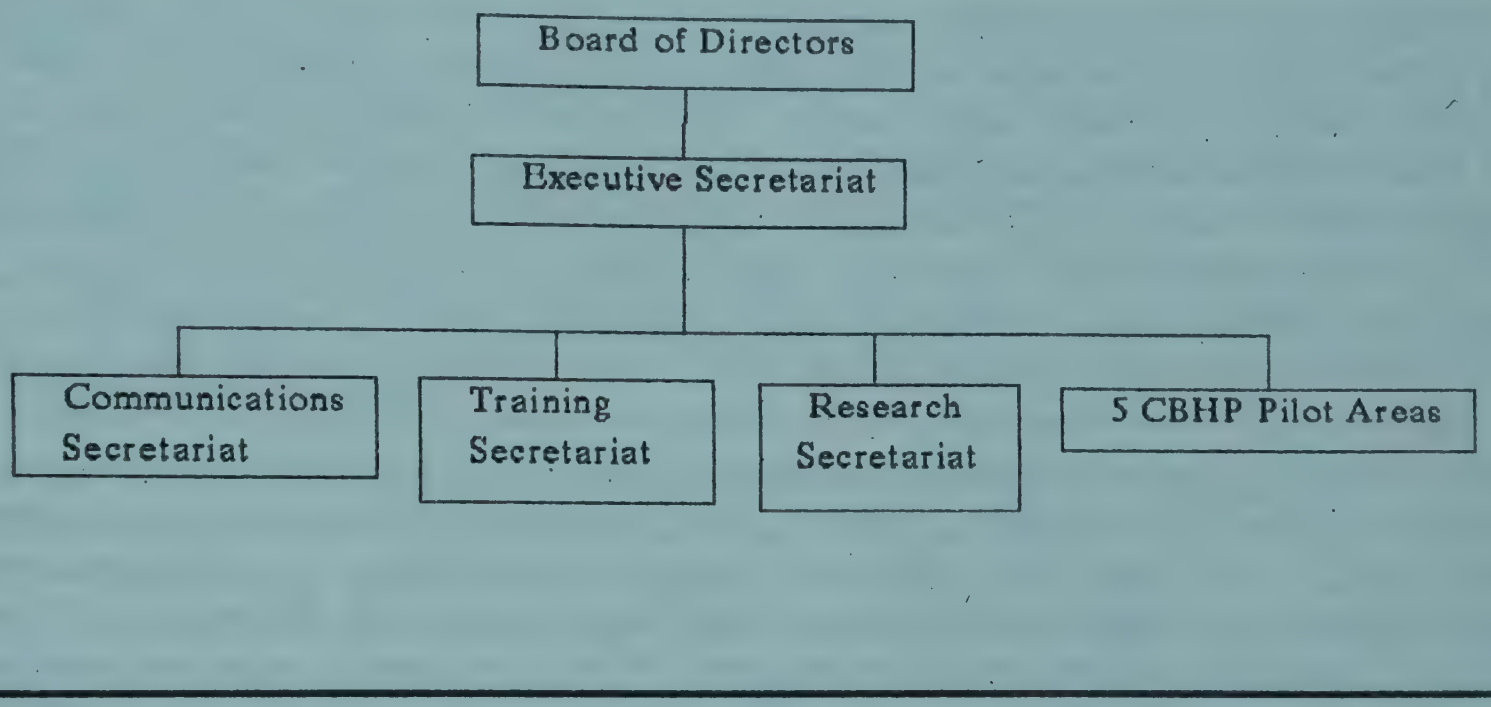
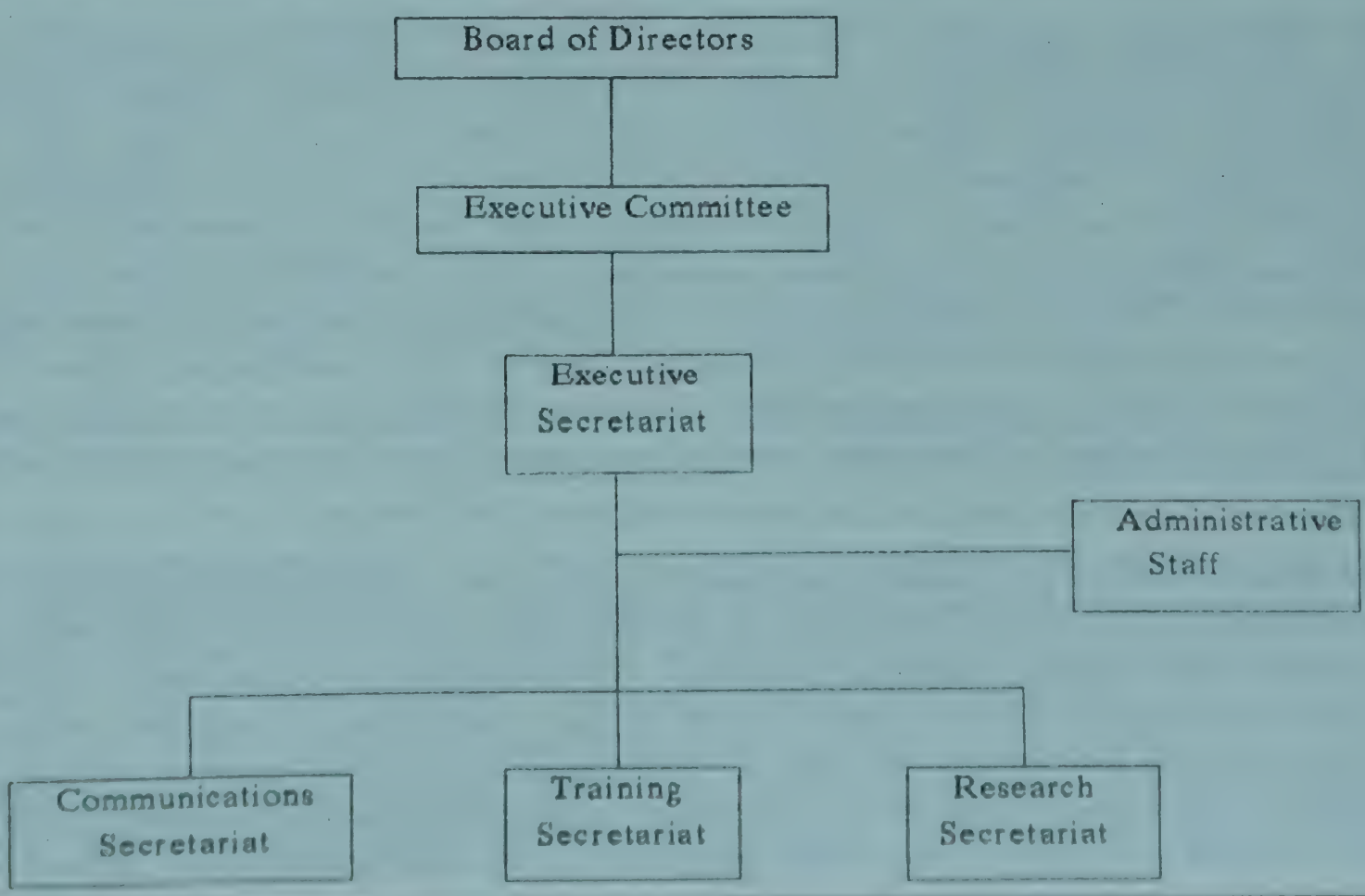


Chart 2. CPHC Organizational Chart, 1989



Communications Coordinator, he/she uses the Tambalan Article Status Chart (see Appendix B) to monitor the status of articles and publications. On the basis of these reports, the Executive Director writes the Progress Reports sent to the funding agency usually every six months also (see Appendix C for complete list). Coordinators began recording in log books only since 1984. The Training Log Book, for example, contains the following information: Date, Requesting Organization, Place, Number and Types of Participation, Topic, Type/Level of Training, and Staff. The Coordinator fills this up for every activity that his/her Secretariat is involved in.

The Training Secretariat, presently composed of a Coordinator and three Trainors, assists CBHP areas in developing their personnel and the communities themselves, through various leadership, organizing, teaching, and health skills seminars. The kinds of trainings given are classified into Basic Health Orientation Seminars, Basic Health Skills Training, Advance Health Skills Training, and Special Skills Trainings (e.g., Leadership Training, Community Organizing, Clinic Management, etc.). A variety of methods are employed in these seminars, ranging from group discussion, role playing, actual demonstration, to creative dramatics, songs and posters. This Secretariat also takes charge of developing training modules and curricula, as well as training materials (see Appendix D for complete list), such as visual aids, books, charts, etc. based on comments and feedback from CBHP field staff. Grassroots training is usually left to local CBHPs or CBHP agencies, as CPHC concentrates on the training of staff. However, once in a while, CPHC trainors also do grassroots training just "to touch base" or to have direct contact and experience. In such cases, they are basically guided by a module they developed called "Methodologies and Strategies in Setting Up CBHPs in Organized and Depressed Communities." Priority is given to organized communities where, as much as possible, there is a health professional who can sustain the program. CPHC also strictly screens the requests to see if these come from genuine people's organizations or not, and what their real intentions are for wanting a CBHP.

The Inter-Agency Committee on Training and Education (IACTED), composed of representatives from the Training Desks of the major CBHP coordinating bodies, decided that training should be CPHC's priority (along with networking, while RM would focus on services, where it has a pioneering role). In response to this, CPHC's Training Secretariat initiated the National Pool of Trainors (NPT) in 1988 in order to systematize training work. The NPT is tasked with developing modules and coming up with training-needs assessments. Under the NPT is a sub-structure, the Regional Pool of Trainors, which undertakes trainings themselves, does on-going assessments of training needs, and identifies the kinds of training to be given. All coordination is done through the NPT which, in turn, is supervised by CPHC's Training Secretariat. The purpose of all this is to share training resources (i.e., manpower, material) and consolidate efforts in curriculum development.

The Research Secretariat, presently composed of a Coordinator and a Research Assistant, directly undertakes and promotes researches on various topics supportive of CBHP work (e.g., acupuncture needle-making, traditional medicine). It is tasked with producing manuals for CBHP use, and collaborating with other research groups through the National Consultation on Research and Documentation held periodically, and the exchange of findings and research methods. This Secretariat is also tasked to improve the organizing, training and evaluation schemes of CBHPs, as well as to maintain the CPHC library which specializes in PHC and related topics. In the first few

years of the Council, this was the line function that lagged behind all the others mainly because it had no clear direction. However, it did contribute valuable data on Philippine medicinal plants and their uses, as well as set up a herbal garden, herbarium and herbal bank. (For a list of evaluation instruments developed and used by the Research Secretariat, see Appendix E.)

The Communications Secretariat is made up of a Coordinator, a part- time artist and a couple of part time writers who are hired on contractual basis. The Secretariat is tasked with providing channels communication and exchange of experiences, information and practical knowledge (e.g., publications, conferences) among CBHP practitioners [see Appendix F for list of publications]. It is directly responsible for putting out Tambalan (the Council's quarterly newsletter), where among others, views of CBHP workers may be expressed and lessons learned from CBHPs may be exchanged. The Secretariat's other functions include revising and updating manuals and other instructional materials; writing solidarity messages, letters to the editor, position papers, etc. in the name of CPHC; reprinting relevant information from other publications, especially Third World sources; facilitating the exchange of publications with other organizations; helping in the documentation of proceedings and seminars; and maintaining media contacts for wider dissemination of CPHC concepts and principles.

The perennial problem of the Communications Secretariat from the beginning until the present is the delay in the publication of issues of Tambalan. The idea behind the publication is to provide CBHP workers with the opportunity to write, even if in rough form which could be edited later by CPHC's technical staff, about their experiences in the field. However, the Secretariat hardly receives any articles or stories from them. The Executive Director cites the reason that "there are no CBHP writers," by which he means although there may be people who can write, they do not necessarily have the proper health orientation. On the other hand, health professionals who have the CBHP orientation claim they do not have the time nor the inclination to write. As an example, even simple questionnaires prepared by CPHC sent to CBHP workers with self-addressed stamped envelopes and needing only checks for responses, are still not returned to the Council. From interviews, it was learned that if CBHP workers have any free time at all, they would much prefer to provide direct health services than to document their experiences. This is a serious problem that has never been resolved in the ten years of Tambalan's editorial life. What the Secretariat has done through the years, instead, is to solicit articles from CPHC staff members who go on periodic program area visits which, although written also from first hand field experiences, is not the same as those that could be written by CBHP workers immersed in barrio life.

As publications and information dissemination form important parts of CPHC's contribution to CBHP work, it is important to mention more about the Council's performance in this area. Tambalan, as a newsletter, has developed considerably since its first issue came out in September 1979 in simple mimeographed form. It was originally planned as the CBHP Review, but a Filipino name was consequently preferred, which means "healing" or "reinforcement," both meanings quite apt. In the effort to resolve the difficulty of keeping up to date, the quarterly sometimes skipped an issue or several were combined together. Tambalan's present format contains a variety of sections, including the following: Editorial; Cover Story which is usually a comprehensive article that is new to CBHPs and which they can apply or learn from; a "How To" instructional column; Folk Medicine; Tales from the Grassroots (which CHW's are supposed to contribute, but instead is written by

CPHC staff more often than not); Drug Information; Food and Nutrition; Disease Column; Health Skills Information; Publications and Resources; Special Features; Literary Section; Pilipino Section; News; and even Cartoons. Any of these articles can be reproduced and translated without permission, but should be distributed free or at cost, which is what frequently happens in local CBHPs where Tambalan articles are used for educational purposes. They serve as topics for community discussion. Tambalan even provides guides for discussion of certain lengthy investigative articles on health related-issues.

This year's Tambalan is again delayed. The latest one was No. 47 (July-September 1988), making an average of 4.7 issues per year for the last ten years. A general policy of the newsletter is its nonacceptance of paid ads from manufacturers or distributors of drugs and medical equipment, since that would go against the basic principles of CBHP. Tambalan, however, accepts subscriptions from individuals and institutions here and abroad. In 1984, 35% of the 1,800 copies for the year were bought by subscribers, while 21% or more were used in seminars. Aside from the local CBHPs, members of the media and foreign development agencies are also sent copies of Tambalan.

Two other publications of CPHC are the Research Series and the PHC Readers' Series. The former consists of the results of research efforts by the Research Secretariat published for the use of CBHP staff, often utilized directly for training. These come in manual form and are given or sold at cost to those within the CPHC network, or sold for eight pesos each to outsiders. The usual procedure for its publication is as follows: if requests for information on First Aid, for example, reach CPHC, it drafts a training module for it. This is then tested five times, and based on the documented input of the participants, plus additional comments, CPHC publishes it as a manual.

The Readers' Series, on the other hand, are taken from original or reprinted articles, speeches, lectures, etc. on health or related matters. While subscriptions are also accepted, 25% of the approximately 2,000 copies per issue are sent free of charge to CBHP staff, while the rest are used for Staff Development Seminars, or as reference materials in training and orientation seminars. In this process, the interlink between training, research, and publications, CPHC's three line functions, is clearly clear. Since 1988, however, the Readers' Series has been incorporated into Tambalan as a section.

In the CPHC organizational structure, although the Board of Directors is the highest policy-making body, it is the Executive Committee that defines the main policies and makes decisions for the Council. The Board of Directors' membership has expanded and contracted through the years. In the early years, it was not so active in real policy-making, but even then, its members already included key persons in CBHP agencies or "experts in various fields connected with PHC," such as traditional medicine, social anthropology, nursing and medical professions, etc. At present, the Board is composed of ten persons: the current Executive Director, the immediate past Executive Director, an anthropologist, an academician, one from traditional medicine, one each from Luzon, Visayas and Mindanao, and the two other major CBHP coordinating bodies (RM and NEHCC). They set the general policies for CPHC for the year.

Since 1983, Board members have been given a greater role in decision-making and setting of policies, programming and actual implementation. They are provided with pertinent documents and regular reports by the staff. Close correspondence and consultations between the Board and the

staff are maintained, basically with the Executive Committee acting as liaison. Board members are now also given the same orientation as the staff concerning CPHC history, assessment of work, scope of tasks (general and particular), and each one's role in implementing tasks. Nevertheless, because they only meet once a year (usually mid-year), the Executive Committee makes the decisions in their absence.

The Executive Committee constitutes the actual policy-making body in the CPHC set-up. It consists of the Executive Director, Administrative Officer, a Board member (usually the former Executive Director who gets elevated to the Board after his/her term), and a member each from RM and NEHCC, organizations directly involved in coordinating CBHPs. They meet once a month, unless there are emergencies. From its constitution, the Board appears like the Inter-Agency Committee. In fact, the reason why the composition is this way is precisely so that, as in the IAC, problems may be threshed out with the other major CBHP coordinating bodies to avoid any duplication of functions or misunderstandings.

The Administrative Staff, as its name implies, handles all matters relating to the day-to-day running of the Council. It is headed by the Administrative Officer, who in practice also serves as the Deputy Executive Director. The present Administrative Staff consists of a clerk-typist (who also functions as the librarian), a secretary, a bookkeeper, and an office worker, who doubles up as messenger and maintenance man.

At present, the CPHC staff has 13 full time and three part- time contractually hired members, compared to 17 of the early years, and even 25 of the period when it was handling several programs at the same time. The present streamlining of personnel and, in fact, understaffing is in anticipation of the end of the Misereor bridge grant in July or August, and the impending fusion of CPHC with the health desks of RM and UM. In general, the turnover of personnel through the years has been more or less normal for an NGO. There have been four Executive Directors since the start of CPHC in 1980, each serving an average of two and a half years. Although there may have been a number of staff members who have moved to better-paying jobs elsewhere because of economic necessity, still it can be said that there are those who continue to be committed to the Council, as evidenced by their prolonged years of service and dedication. For example, the current Executive Director, who is on some kind of "leave" in order to set up the Center for International Health Concerns, has been with CPHC since 1980, almost from its inception. The Administrative Officer, on the other hand, joined the Council in 1986, but was assigned for a long period of time before that to a CBHP in Agusan, Mindanao. Both of them are registered nurses.

Finances and Financial Management

In the ten years of its existence, CPHC has kept a fairly regular and organized record of its finances. Audited financial statements prepared by the office of the Redor, Gonzales, Dejoras and Co., are available from 1980 until September 30, 1988, except for the full year of 1981. This

Table 1: CPHC Fund Balances December 31, 1980 - September 1988

Period Ending	End of Year Balance x(Deficiency)	Misereor/ Zentraletelle Grants	Other Donations	Other Income	Sale of Materials	Excess (Deficiency) Income over Expenses
1980 Dec. 31	P402,646.04	P 829,535.20				P402,646.04
1981 Dec. 31	(P281,354.98)					
1982 Dec. 31	(P308,336.96)	P 513,127.77	P205,764.73	P 574.01	P 6,345.92	(P 26,481.98)
1983 Dec. 31	(P200,151.18)	P 788,417.71	P90,821.91	P 43,460.00	P 3,946.20	P108,185.78
1984 Dec. 31	(P 93,811.46)	P 928,064.62	P8,380.15	P 175,557.17	P6,262.20	P106,339.72
1985 Mar. 31	(P190,309.80)		P 13,932.95	P120,360.00	P 2,039.70	(P 96,498.34)
1986 Mar. 31	(P 201,012.18)	P 908,780.40	P125,965.35	P 11,957.08	P12,109.59	(P 10,702.38)
1987 Mar 31	(P 655,624.44)	P 394,127.60	P 38,144.95	P 175.90	P 16,263.50	(P 454,612.26)
1988 Mar. 31	(P 411,837.69)	P1,994,973.92	P 6,803.20	P 411.00	P 26,712.10	P243,786.75
1988 Sep. 30	(P 55,349.15)	P 830,510.91	P351,318.80	P 881.13	P 14,374.20	P 356,488.54
TOTALS		P 7,187,538.13	P 841,132.04	P 353,376.29	P 88,053.41	

Table 2. CPHC Expenses December 31, 1980 - September 30, 1988

Period Ending	Total Expenses	Top Three Expenditures		
		Honoraria, Salaries. Allowances	Regional Meetings, Seminars,	Printing and Supplies
1980 Dec. 31	P 431,484.31	P 176,110.00	P 48,250.00	P 40,286.60
1981 Dec. 31				
1982 Dec. 31	P 767,310.61	P 301,268.00	P 168,146.35	P 139,839.95
1983 Dec. 31	P 828,513.26	P 266,700.00	P 235,433.85	P165,451.70
1984 Dec. 31	P 992,424.59	P 392,800.00	P 263,715.00	P156,021.20
1985 Mar. 31	P 243,162.18	P 102,600.00	P 8,004.95	P 33,255.80
1986 Mar. 31	P1,093,362.34	P 444,600.00	P 267,218.00	P117,619.35
1987 Mar. 31	P 939,325.64	P 444,600.00	P 130,007.80	P 89,559.55
1988 Mar. 31	P1,802,514.20	P 489,756.25	P 777,417.40	P158,718.32
1988 Sep. 30	P 842,668.39	P 312,380.00	P 137,708.30	P 66,421.00
Total	P7,940,765.52	P2,930,814.25	P2,035,901.65	P926,386.87

gap may be attributed to the fact that CPHC seemed to have been left without steady funding for a year in 1981.

The regular Progress Reports do not show how the Council subsisted during those 12 months, although a letter from Prof. Ponce Bennagen (CPHC Chairman of the Board) addressed to Misereor dated July 23, 1981, states that the Council was "constrained to apply for bridge funding from the Asia Partnership for Human Development for the last three months of 1981." From interviews with CPHC staff, it was learned that the Council also occasionally receives small grants and donations for specific projects or programs, but that these as a rule have a separate accounting in order to avoid confusion. An example was the grant received in January 1980 from the Maryknoll Fathers for the CPHC Tambalan Research Group to produce a Primer/Information Sheet on Medicinal Plants. There was also a fleeting mention in one of the Progress Reports of some contributory funding received from the Christian Conference of Asia. However, because there were no specific statements about 1981, it may be presumed that this prolonged period of financial limitations was what mainly caused the Council to incur large budget deficiencies, beginning in 1981-1982 and every year thereafter, as reflected in the Statements of Income, Expenses and Changes in Fund Deficiency from 1982 until 1988 [see following tables comparing yearly fund balances or deficiencies, and other significant items].

The series of fund deficiencies at the end of every year since 1981 may have been further aggravated by spending more than what was available at certain times, a not unlikely possibility, given expansion in CPHC's services and programs. The total expenses disbursed went over the total income received in four out of the nine years recorded, at one time even going over by as much as 51% (in 1987). In the years when there would be an excess of income over expenditure, the excess income often had to be used to pay for the fund deficiency accumulated the year before. However, sometimes this was not enough to cancel it, thus ending with a deficiency again carried over to the beginning of the next year -- somewhat like a "deficit cycle." This may account for the fact that there was never a year of the CPHC being "in the black," so to speak, except during the very first year of operation, when a fund balance of P402,646.04 was recorded at the end of 1980.

Queried about the possible reasons for the yearly fund deficiency since 1981, a CPHC staff member cited a variety of reasons. One is the delay in the remittance of grants to the program, as what happened, for example, in 1981. CPHC did not really "lose" its funding that year, rather it was just that the renewed grant arrived almost a year late, causing CPHC to compress its operations and to borrow or solicit emergency funding. These delays appear to be caused by late transactions between the grant recipient and the donor agency, as well as some problems of bureaucracy.

Another reason is that the funding agency sometimes trims the budget proposal, forcing CPHC to adjust its budget lines with great difficulty. This is what happened in 1982, when the Council was strongly urged to increase its counterpart contribution "in order to assure the continuity of the CPHC and to become independent by lessening its dependence on outside assistance."

Taking up this last point, we can see that the total (from 1980-1988, September) of all the other sources of income (i.e., sale of materials and two unspecified sources) outside of the Misereor/Zentralstelle Grants and interest earnings, is P1,282,561.74. If we can consider this as the

total local counterpart contribution, we can say that it makes up about one sixth or 16% of the total grant from Misereor/Zentralstelle (P7,187,538.13) for the ten-year period.

The three consistently top expenditures from 1980-88 went to Honoraria, Salaries and Allowances (37% of total); Regional Meetings, Consultations and Seminars (26%); and to Printing and Supplies (12.%). Considering that CPHC is a national coordinating body, it is not surprising to see a substantial portion of their budget go to their two principal functions of conducting and coordinating conferences, as well as publishing materials (mostly for networking, training and information dissemination). As for the Honoraria, Salaries and Allowances, there has not really been major increases during the ten-year period. In 1980 at the beginning of the CPHC operations, the Executive Officer (now called Executive Director) received a monthly salary of P2,500, while a Coordinator of a Secretariat received P2,000, and a Clerk-Typist was given P800. In 1984, these had increased by 50% to: P3,750 for the Executive Officer, P3,000 for the coordinator, by 113% for the Clerk-Typist who received P1,700. An estimate of present 1989 salary rates would show that a CPHC staff member would be receiving, on the average, P4,000 a month. CPHC's planning of its finances is a fairly involved process. The Executive Director, in consultation with the Executive Committee, first drafts a project proposal, usually for a 3-year period, covering the CPHC's proposed activities and the financial requirements for these. The project proposal has to be approved by CPHC's Board of Directors prior to submission to the funding agency (Misereor).

Once the project proposal is approved by the funding agency, CPHC breaks down the three-year program into yearly work and financial plans. After the plans are approved by the Board of Directors, the Executive Secretariat prepares a budget which is subsequently forwarded to the Administrative Officer (AO), who ensures that it does not exceed the amounts approved by the Board as stipulated in the project proposal. Funds are disbursed by the AO on the 24th and 29th days of the month.

The AO implements the financial policies which have been approved by the Board, prepared by the Coordinators and presented for approval to the Executive Committee. At present, CPHC observes rigorous policies regarding the flow of funds, documentation of financial transactions, bookkeeping, and interpretation of results of financial performance, to ensure that funds are properly disbursed. (See Appendix G for the list of forms used.) To further ensure financial integrity, the independent auditing firm of Redor, Gonzales, Dejoras & Co. conducts an audit of CPHC's finances bi-annually.

Field Visits

San Jose Carmona, Cavite, June 15, 1989.

The visit to Carmona was simply an exploratory one, based on the curiosity to find out what has happened to a community- based health program established by CPHC in 1980 as one of its first pilot projects. It was phased out just two years after it was started and no contact was maintained with the Council in the past eight years, until the evaluator's visit. San Jose, located just an hour or so from Manila, was made into a resettlement area by the Marcos administration where squatters

from Quezon City, Intramuros, Tondo, Baclaran, Pasay and Caloocan were relocated, some as early as 1968. The population has more than doubled in the last decade, since there were only 10,000 inhabitants in 1979, about the time CPHC set up its CBHP, while there are now about 22,000 people in the area. The community problems seem to have remained the same though in those ten years. Obtaining gainful employment is still a major problem, so that many have to look for jobs in Manila and commute daily. Some earn by selling dried fish, pillows, and food, or by offering their services as construction workers, drivers, security guards, or factory workers. A notable point in this visit is the observable contrast between the new concrete houses of residents who have relatives working overseas (many in Saudi Arabia), and the run-down homes of those who do not. This shows that the search for employment opportunities has extended far beyond Metro Manila.

During the visit, two interviews were conducted: one with Aling Ading, head of the mother's group called Samahan ng mga Kababaihan para sa Kalusugan at Kaunlaran (SK3K), and the other with the group's health coordinator (Aling Susa), although two other members were also present and contributed information from time to time. The interviews were done in the group's Clinic/Office, a house belonging to a relative of Aling Ading's who died, and whose son is renting it out to the group for P200 a month.

The existing local organization in 1980 was called Kilusang Pangkalusugan ng Sambayanan (KPS). They were referred to CPHC by AKAP in their request to be given health training. The KPS provided most of the leaders who were trained as CHW's in the early years. The two interviewees were both part of that first group of 12 who underwent training in first aid, use of herbal medicine, acupuncture, acupressure, ventosa, and "all sorts of other trainings" to which they confess not remembering everything anymore today. The criteria for having been chosen as CHW's were: (1) they had the time to devote to CHW work; (2) they were approachable; and (3) they were willing to share their knowledge with others. CPHC sent two nurses and a doctor to live in the area and organize their training.

By 1981, the CHWs' training was completed and they were being encouraged to share their knowledge and skills with the community, while CPHC merely played a supportive role. In 1982 when CPHC decided to phase out the area, the women decided to register their group officially as SK3K. In 1986, perhaps for political reasons, San Jose was divided into six barangays just before the snap presidential elections. The six are: San Jose, Teniente Tiago, Gregoria de Jesus, Nicolasa Virata, Francisco Reyes, and Francisco de Castro. Again for unknown reasons, their area which belonged to Barangay Nicolasa Virata, was moved from being under the jurisdiction of Carmona to that of Gen. Mariano Alvarez.

SK3K's membership fluctuated during those years, but the organization has survived to the present with 44 members. Since 1987, they have been under the supervision of a provincial group called KEDFI (Victor Kiamzon Educational Foundation, Inc.), which sends a doctor once a month for community consultation. KEDFI also gives them health trainings such as the Basic Orientation, Cleanliness of Surroundings, Maternal and Child Care, and even minor surgery (experiments are carried out on chickens). However, none of the members has dared to try the last one yet. Asked to compare their training before and now: they said it was similar in that both were participatory. [A check with CPHC showed that KEDFI is one of those they maintain linkage with].

SK3K's health component is rather impressive, showing what a well organized group can do. They have a herbal garden on a plot behind the church which the parish priest allows them to use. They pay someone P15 every 15 days to water the garden. Their organization is divided into 5 committees with the following no. of members: Health - 23, Organization - 4, Social - 4, Economic - 8, and Education - 5. Although there are 23 in Health, it was clarified that all 44 members undergo the trainings. Their next health training was scheduled for June 24. They also plan to put up a herbal garden in each of the 6 barangays and to hold a "Herbal Botika" before October. They plan to sponsor a Herbal Forum for the community involving the school, and maybe even Herbal Demonstrations, in people's homes so they can grow herbs in their backyard. They have a general assembly scheduled for July 9, although they have semi-assemblies every 3 months, and a gathering with barangay captains, mayors and other local politicians every 6 months. They are in the process of including men in their trainings, but they want them organized as a separate organization.

Among their past activities (which are well documented in colored photos displayed on a poster), they have held a herbal exhibit, a get-together with politicians and local military leaders (to avoid harassments later), and a picture documentation. They have also given lectures for the Catholic Relief Services on what they have learned. Asked about their relationship with the government's Rural Health Unit, they said they maintain good relations and that, in fact, after informing the RHU about their training and activities, they were given "barangay health worker" cards. They feel, though, that RHU training is inferior to theirs as it is "mechanical" and "not explained."

Outside of health, their other activities include: running a Learning Center for pre-school children (one of their members is the teacher) where they charge a matriculation of P10.00, plus P5.00 a month for snacks; managing a coop store; hog-raising (from a capital investment loan received from the Farmer's Assistance Board); and rice trading. The last was facilitated by a P7,000-loan from an NGO known as IDEAS, with which they bought rice from Binan. They sell rice to their members at P4.30/kilo on installment basis (although each has to give a down payment of P100, and pays up in one month.). They have also started organizing among the youth, as there is a serious problem in the community of drug addiction (solvent sniffing, cough syrup, marijuana smoking), juvenile delinquency, and a high drop-out rate from school. Right now they have managed to organize the young people into the Spiritual Reading Group, Sandigan Youth Action Group (out-of-school youth), and Malayang Sining ng Teatro ng mga Kabataan sa Resettlement Area (MASKARA). They have plans of training the youth sector in health.

To maintain their organization, they have fund-raising activities once in a while. From the hog-raising activity, they are able to raise some money since 5% of the profits goes to SK3K. They charge a minimal membership fee of P1.00 per member. To strengthen their organization's links, as well as to practice their CHW work, Aling Ading and other trained CHWs reserve 3 days a month for "area visits," meaning visits to individual homes of members and non-members. They plan to increase their membership to 50. Regarding the community's acceptance of herbal and traditional medicine, Aling Ading says that because they are close enough to Manila or some other big hospitals, people still prefer to go to a doctor or a hospital, if they can afford it. It is those with no money who turn to them and use herbal medicine. What they would like is for a nurse to live in their area on a permanent or long-term basis, so that they can upgrade their skills, as well as consult her whenever they encounter problems.

As a community-based health program established ten years ago, this one in Barangay Nicolas Virata seems to be doing well, given the conditions of economic depression that the community has had to go through. The women's group is cohesive, creative, and has far-reaching visions about its role in the community. The nature of their activities and the systematic way that they manage their organization is worthy of emulation in other program areas. However, as happens in many organizations, they do not seem to have been able to pass on or rotate leadership in their group (e.g., Aling Ading has been head since 1984). While it is heartening to see the same faces with their selfless commitment and dedication to what they are doing even after ten years, it does not speak too well of their ability to train new leaders, pass on their knowledge, and step aside so as the new ones can take over. On the other hand, maybe the process really takes longer.

CPHC may be able to help them now in a comprehensive assessment and evaluation of their whole organization, and not only of the health program, after ten years of existence. Now that communication has been re-established with the Council, CPHC may be in a position to link them up with nurses' or doctors' groups they can work with. The PYHP may also be able to help them. Although links have now been renewed between the Council and SK3K, this experience seems to point to a flaw in CPHC. Despite its success in setting up programs, it has been unable, either through lack of resources or an adequate system, to monitor the developments of these programs.

HIDS - Pampanga, June 23, 1989

HIDS or Health Integrated Development Services was officially registered with the Securities and Exchange Commission on December 10, 1984. However, its origin may be traced to a health project started by the Rural Missionaries in Bátaan. Due to adverse social conditions, the project was forced to transfer to Pampanga in 1982. There, committed health professionals and other health staff were recruited so that HIDS was formed two years later, with the objective of developing self-reliance in health care through community participation and leadership, and through maximum utilization of local health resources. HIDS is envisioned to be a regional body concerned with the sponsoring of PHC programs and the promotion of PHC among NGOs. Presently, four provinces in Region III have HIDS programs: Pampanga, Nueva Ecija, Bulacan, and Bataan.

The objective of the visit to Pampanga was to examine the extent of the relationship between CPHC, as a coordinating body, and one of the agencies in its network -- in this case, HIDS-Pampanga. The evaluator tried to trace the areas of contact, collaboration, and scope of service delivered, if any, from the Council to HIDS, and all the way down to the local CHWs trained by HIDS in two barangays. Several people were interviewed during the visit. In San Fernando, where HIDS maintains a separate office and staff house, three people were interviewed: the Program Coordinator (who will be giving up that position soon to be Regional Coordinator for all Central Luzon CBHPs), the Secretary-Bookkeeper, and the Training Coordinator (formerly a CHW, but later trained to become a regular staff member. At that moment, due to understaffing, he was single-handedly overseeing nine HIDS program areas in Pampanga). The Program Coordinator and the Training Coordinator also accompanied the evaluator to the two barangays visited. In Barangay Piring, Mexico, Pampanga, three CHWs were interviewed, while in San Carlos, San Luis, Pampanga, two CHWs provided information.

It may be good to mention at this point that the evaluator is grateful to the HIDS staff for being very helpful and accommodating despite adverse conditions. For one thing, the political environment in the province was rather delicate at the time of the visit due to increased militarization and frequent violent encounters between government troops and insurgents. This directly affected eight out of HIDS' nine project areas which were in militarized zones. This meant that military checkpoints were set up everywhere and many CHWs were constantly harassed, proving a hindrance to their mobility (e.g., attendance at meetings and trainings went down, house calls to patients were made difficult). As a consequence, many programs were delayed.

Another adverse condition faced by HIDS-Pampanga is the lack of funding. At the time of the visit, the staff had not been paid their salaries since December last year, and they were operating only on very limited funds borrowed from sympathetic friends. In fact, it was on the morning of the interview that they received word from Cebemo, informing them of the approval for a bridge grant for their program.

The relationship between CPHC and HIDS may be said to operate on two levels: direct and indirect. On the level of direct contact, regular Progress Reports are usually sent by HIDS to the Council every six months, as evidenced by the thick file on HIDS at the CPHC office. However, at the time of the visit, it was discovered that HIDS had inadvertently forgotten to send copies of their report for the last two years, a fault that was immediately rectified.

Aside from the reports, contact is maintained by personal visits, usually from HIDS to CPHC every three months or so. This is facilitated by the proximity of San Fernando to Manila. From CPHC's side, they regularly send training materials and other publications (Tambalan, etc.) to HIDS. For example, they sent a book for the use of CHWs, entitled "Ating Kalusugan, Ating Buhay" (Our Health, Our Lives), and the latest one sent was a Module on the Training Curriculum of Basic and Advanced Health Skills (February 1988). Staff Development Seminars and other types of meetings are also conducted by CPHC on the local level, upon request or when tasked to do so by a national conference. For example, in 1985, HIDS requested a consultation with CPHC and the Medical Action Group (MAG) regarding appropriate methods for recruiting health professionals to participate in CBHP activities. Pampanga is a province with many health professionals and was also one of the pilot areas for the government's PHC programs. Despite this, the HIDS staff had been having difficulty in involving local health professionals in the activities of the health program. In the consultation, both CPHC and MAG staffs shared different methods being used in different regions to encourage greater participation of local health professionals. The meeting seemed fruitful because from then, HIDS reported an increase in the number of health professionals it was able to tap.

Another manner of direct contact between CPHC and HIDS is when the latter calls for a program evaluation. Before, because of HIDS' historical links with RM, NASSA would always do their evaluations. At present, however, it is CPHC that provides them this service. For example, CPHC conducted the program evaluation of HIDS-Nueva Ecija last May 1989, where they identified the strengths, weaknesses, problems, failures and success factors in the implementation of the health program. This is done by determining the scope of community participation and the involvement of the local organization in the whole program; finding out the extent of the linkages, coordination and organizing work of the program; determining the level and types of skills of the CHWs; comparing

the program's approach, activities and services with the program's objectives, to measure accomplishments; and finally, coming up with recommendations for further future implementation of the program.

On the level of indirect contact between CPHC and HIDS, there are the national and regional CBHP consultations and conferences which CPHC usually sponsors yearly and provides resource persons for, and where HIDS sends its representatives. This may be considered still part of the contact between the two, but on an indirect level because no service is directed specifically to HIDS. Furthermore, CPHC and HIDS also coincide occasionally in certain activities, for the most part multisectoral fora or campaigns. On the same indirect level, it was found that CPHC uses HIDS as its unofficial local network, meaning most correspondence, following-up responses, and contacting of other programs in Pampanga by CPHC are done through the help of HIDS. This is due to the good working relationship existing between the two organizations, as well as the communication accessibility of HIDS (i.e., there is a telephone in their staff house and another next door to their office, which they are allowed to use). Moreover, because of Pampanga's proximity and easy transportation access from Manila, the Council staff often accompanies or refers foreign visitors on exposure trips to HIDS to visit their program areas. Below is an incomplete list of activities where CPHC had some contact with HIDS, covering the year 1983-1988 (HIDS was founded 1983-1984).

1) Selected HIDS staff members attended a Seminar on Community- Based Research and Documentation for PHC, sponsored by CPHC on August 29-31, 1983.

2) HIDS' Community Education Coordinator was recruited in November 1983. She was formerly a member of the CPHC Training Secretariat and had served as the Acting Coordinator of the Outreach Health Education Program for Workers.

3) Basic Health Skills Training for Trainors (sponsored jointly by CPHC and RM-CBHDP) on September 25 - October 4,1983, for 12 staff members and two local trainors from HIDS.

4) CPHC referred 2 exposuree-nurses from Norway to HIDS in March 1985 to observe how PHC was being practiced in the rural areas by an NGO.

5) CPHC usually provides resource persons, speakers, lecturers, etc. for HIDS symposia (e.g., CPHC Executive Director, Dr. Delen de la Paz, was speaker at April 21, 1985 symposia; CPHC staff served as resource persons for HIDS' Communication Skills Staff Development Seminar, July, 1986).

6) CPHC referred Anita Hardon, a Dutch researcher temporarily based in Health Action Information Network (HAIN), to HIDS for a visit to Mexico, Pampanga for 3 days.

7) CPHC sponsored the Luzon-wide CBHP Consultation Workshop (October 22-26, 1985) which HIDS participated in.

8) CPHC referred 2 exposurees to HIDS on separate occasions.

9) CPHC referred an American doctor to HIDS, who was looking for a health project in Central Luzon to work with (first half 1986), but the plan was eventually aborted.

10) CPHC staffer acted as facilitator during a field trip of HIDS' CHWs to medicinal plant garden run by the Urban Missionaries in Valenzuela, Metro Manila (second half of 1986).

11) CPHC (together with RM and NASSA) helped in an over-all evaluation (internal and external) of the HIDS project in Pampanga (first half 1988).

12) CPHC sponsored a National Training evaluation of CBHPs (February 22-28, 1988) which HIDS attended.

13) CPHC (with RM) sponsored a National Conference of CBHPs on November 26 - December 3, 1988 where HIDS sent delegates.

Barangay Piring, Mexico, Pampanga

One of the HIDS program areas that is relatively accessible from Manila is Piring in Mexico, Pampanga. It was formerly known as Dolores, but for some reason got its name changed. It is the barrio adjacent to San Carlos, and is bounded by the barrios of Lang and San Pablo. The main sources of income are in agriculture and seasonal jobs in the urban centers of the province or in Manila. According to a 1986 report, the barrio had 119 families and a total population of 1,065 persons (approximately 8.9 members in each family). This has increased slightly in 1989 because the interviewee said that there were now 131 families, therefore a population of about 1,166 persons (the interviewee herself had 14 members in her family).

In contrast to most areas handled by HIDS, there was no existing organization in Piring when they started there in 1986. HIDS immediately organized a mother's group and began training 10 potential CHWs, two of whom dropped out due to pressing family duties. A year after their training, the CHWs had set up herbal gardens in some of their backyards and had prepared an updated survey of 0-6 yrs. old children for their immunization and nutrition records. Even then, the CHWs were already active in house-to-house visits, where they tried to sell the idea of traditional medicine. Last year, they launched a health campaign on safe water sources. After the analysis and classification of water samples and sources (done in cooperation with the Provincial Health Office because they have access to the laboratory), recommendations were made regarding the use of wells found to be unsafe.

All three CHWs interviewed in the area maintain some sort of other livelihood activity, ranging from selling bananas, mango, and T-shirts, to being a collector for jueteng bets (jueteng is a local gambling activity that is extremely popular in Pampanga). One of the interviewees, Atching Zeny ("Atching" is a form of address for older women, equivalent to the Tagalog "Aling") admitted she could now easily treat cold, fever, diarrhea, simple wounds or abrasions with a combination of acupressure, ventosa, and herbal medicines. She is said to be able to distinguish different types of coughing and their causes. Although they have been exposed to it, they do not use moxibustion probably because it is more tedious than any of the other methods. The group has not been given

acupuncture training because it is too rigid and requires a lot of time. Atching Zeny also works as a "hilot" (local midwife), a skill she says she learned from observation and experience.

All the CHWs keep records on their patients, most of whom pay them very minimally in cash, if not in kind. They are trained to tell the symptoms for the use of antibiotics, which they sometimes prescribe following the philosophy of rational drug use. For the cases beyond their competence, they do referrals to San Fernando doctors (or the San Fernando hospital), with whom HIDS has on-going arrangements. In one case, where they referred a woman needing a Caesarean operation to a health professional/ obstetrician contacted by HIDS, instead of being charged the "normal" P2,000, the patient was only charged P700. Asked about their problems as CHWS, they cite lack of medicines (antibiotics) as a major difficulty. They also mentioned the militarization of a neighboring barrio, and the insecurity of the government doctor assigned to the barangay (feels threatened by rivalry) as being problems. A common problem for all was not being able to earn enough for the support of their families. Still and all, their morale was high and rapport among each other was very good. They were very enthusiastic about holding another barrio "clinic" and dental check-up day as in the past, when volunteer doctors and dentists came to render free consultations and services through the auspices of HIDS and some donor organization. The CHWs then served as medical assistants.

Regarding communication with HIDS, and through them with CPHC, the CHWs submit regular progress reports to the HIDS' Area Coordinator every six months containing their various activities related to training, services, linkages, and organizing. These, in turn, are used by the HIDS Program Coordinator to make his own progress reports for the program, copies of which are then sent to CPHC. During the interview, it was noted that the CHWs receive training and educational materials from HIDS, many of which were provided by CPHC. HIDS usually duplicates selected or whole texts sent by CPHC in order to disseminate these to their local CHWs. Sometimes, translations to the local dialect are done by HIDS. Examples of the materials from CPHC that have reached the CHWs through HIDs are: a manual on first aid and the book "Ating Buhay, Ating Kalusugan," considered to be the "Bible" of CHWs. Presently, the CHWs are training 7 new people as potential CHWs, meeting once or twice a month at different homes.

Barangay San Carlos,San Luis, Pampanga

Two CHWs were interviewed in San Carlos - Atching Glo and Tatang Kulas. Atching Glo has six children. The eldest is in college and two are in high school. Her husband is a carpenter, while she works in the rice field or sells food during her free time. Tatang Kulas, on the other hand sells "a variety of things." Both of them underwent health training by HIDS as early as 1983, when the program first transferred from Bataan. Of the 42 CHWs trained then, there were only three left now (the third one, I was able to visit in her house but did not have enough time to interview). This sharp decline is mainly due to the economic need of the volunteers to have better paying jobs (or several jobs) in order to support their families.

There are presently 500 families in the barangay, distributed in five puroks (a subdivision of a barangay). The inactive CHWs actually still practice what they learned, but their training has not

been upgraded. Despite their decreasing numbers, the CHWs were able to hold some very successful activities in the recent past. In 1987, they sponsored three barrio consultation clinics where the needs of some 75 patients were looked after. In the same year, they started the sampling of potable water sources, as part of an environmental sanitation campaign. The Provincial Health Office provided them with bottles which they filled with water samples from available water sources (both public and private) in their community. These were later analyzed and classified, and the proper recommendations were made. Last year, they launched a campaign for the construction of sanitary toilets. HIDS was able to get 50 plastic toilet bowls from the RHU which were distributed among the barrio folk to set up in their homes, while the CHWs monitored the construction and use of the toilets. Atching Glo says among her CHW activities are: curing colds, flu, asthma, sprains, etc.; supervising the weighing and feeding programs of children; TB referrals. Tatang Kulas says he uses a combination of herbal medicine and acupressure. Moxibustion is not usually employed due to the inconvenience of drying leaves and burning. Both say they can make ointments from plants but have some difficulty growing in their area because the land is rocky. Both keep records on all their patients and their illnesses. Atching Glo also serves as a "hilot" (midwife) and she says she uses acupressure for toothaches, sprains, and childbirth. They both give lectures on various topics in meetings that HIDS arranges. However, due to the lack of staff at HIDS, this activity has been greatly hampered. They are now concentrating on training five new recruits who started just February of this year.

Regarding their relations with the RHU, they say, they receive some help by way of medicines for TB, fevers, diarrhea; sputum analysis; and immunization of children. Since the vaccines are never sufficient, only those below one year old get immunized. Among the trainings given to them by HIDS are: First Aid, Basic Health Skills, Family Planning, and soon, Acupuncture (scheduled for July). Among the materials distributed to them from HIDS were the book "Ating Buhay, Ating Kalusugan," and old copies of the Philippine Index of Medical Specialities (PIMS) which contain the drugs and medicines most used and their generic names, among other information. HIDS collects old, discarded copies of PIMS from doctors (it is re-edited and published every three months), which they distribute among CHWs.

Like in Piring, the nearest hospital to their barrio is not very far, but also not very good, so that those who can afford it, go to the big cities for medical care. When separately questioned about the decreased CHW activity in San Carlos, HIDS staff members say there was a lack of community organizing work there. The area was supposedly organized when they invited HIDS to train them, but obviously they were not, or at least, not organized enough. This could be contrasted with Piring, where HIDS did the community organizing work as well as the training. The HIDS staff, however, admitted that their own present lack of personnel to rekindle interest and organization has greatly limited their programs in San Carlos. Perhaps it is Atching Glo's explanation that is the most logical and believable. She said, "people believe in traditional medicine but, due to economic needs, they have no time to devote to being CHWs." This became even clearer when we found out that Atching Glo herself was waiting for her papers to be processed so that she could go to Malaysia as a domestic helper.

Conclusions

Today, ten years after its establishment, sufficient time may have elapsed for the CPHC to look back and assess the valuable insights it has gained in order to draw important lessons for its future long-term plans. The Council's decade- long history has been characterized by continuous efforts to learn from accumulated positive and negative experiences in the promotion of the community-based approach to PHC. The distinguishing feature of CPHC, in comparison with other groups in this Impact Evaluation, is its unique mandate to primarily coordinate the agencies, programs, and groups committed to this cause -- a case of *primus inter pares* perhaps. Moreover, unlike the other bodies, it has no direct health delivery services (i.e., no clinics, labs, community organizing, etc.), but instead offers more technical services such as training, publication and dissemination of materials, and networking.

Although it took some time for CPHC to assume and practice its primary function of coordination, this may be understandable in a field that, to begin with, did not have a set blueprint or precedent to follow. Some may argue that the Council's coordinating role was clear from the beginning, except it got "diverted" into other activities in the initial years. Nevertheless, its having tried its hand at operating CBHPs at the start was perhaps a necessary "mistake" it had to commit in order to establish firsthand contact and experience in grassroots work, thus gaining some credibility among the local CBHPs it sought to coordinate.

Also, in the early years, there were unmet expectations by other coordinating bodies from CPHC, even as the Council was rather unclear about these. Furthermore, CPHC seemed to be in an awkward position, that of a "novice" in CBHP work trying to coordinate these giant bodies of RM, NEHCC, CBHS, etc. who were pioneers in the field. At the time, there was admittedly some difficulty in enforcing the idea of a coordinating body (CPHC) "coordinating" still other coordinating bodies. A solution was, of course, found in expanding the Council's Board of Directors to include representatives from these other organizations, thereby articulating a more unified view about CBHP's general direction and thrusts, and CPHC's role in it.

Through the years, new structures and links have been established in CPHC's serious pursuit of its principal mandate. Today, the Council carries out its coordinating and networking role on three levels. First, it links CBHPs around the country with each other through island-wide, regional, and sub-regional coordinating bodies who meet periodically in various conferences and consultations sponsored by CPHC (Only CATCH, the island-wide coordinating body for the Visayas is fully operational at the moment). Although these structures and substructures may appear more bureaucratic, they actually provide a more systematic line of communication from the Council to the local CBHP. In addition, CBHPs are also linked with each other through CPHC publications and through the newly created National Pool of Trainors (perhaps a similar consortium could be organized among the research groups working on health). Indirectly, the Council links CBHPs by gathering individual program information on them, through such instruments as Program Evaluation Reports, Area Visits, and the recently revised (1989) Program Questionnaire (see Appendix for samples). In this way, CPHC can come up with a comprehensive view of CBHPs in the country.

Secondly, the Council links CBHPs with health professionals, and other sectors so that possible areas of exchange and assistance can be explored and developed. A concrete example is through the Philippine Youth Health Program and groups like MAG. It may be worth examining the possibility of reviving the "Friends of PHC," an idea brought up in 1984 to gather a group of physicians sympathetic to the CBHP philosophy, who are willing to receive referrals of secondary and tertiary care patients from CBHPs. This may be done on a provincial or city level.

Thirdly, the Council links CBHPs with international groups and networks, mainly through exposure visits, referrals, and information exchange. This is perhaps the weakest link of the three, which CPHC is presently trying to address by concentrating efforts on setting up the Center for International Health Concerns (CIHC-Philippines). CIHC will be tasked to systematically coordinate all solidarity relations and work of various health programs on a people-to-people basis, as well as the exchange of information and publications with overseas groups.

In the manner that these mechanisms for coordinating CBHPs become more firmly established, it is envisioned that much of the activity will probably take place at the sub-regional and regional levels, hence there is a need for strong coordinating centers at these levels. CPHC's vital role then would be linking the regional groups in the three major islands to one another, to the health sector which is principally concentrated in Metro Manila and the rest of Luzon, and to support and solidarity groups abroad. The long-term vision is that where CPHC will mainly serve as a central resource and referral body for CBHPs, less in terms of the services it can provide directly, but more as a clearing house for requests to be fanned out to other organizations. When all of the above is in place and functioning, it must certainly and inevitably affect and influence government policies and decisions concerning the PHC delivery system in the country. The acceptance of the community- based approach to PHC in the Philippines would then be a fait accompli.

Finally, the following are some observations, ideas, and initial suggestions that came about while doing the case study. They are included here simply as additional information.

1) One of the basic problems of CPHC is that it is unable to monitor on a sustained basis the developments of the programs it helps to set up. This was admitted as much in one of the program reports and in the case of San Jose, Carmona, Cavite, the site of the Council's first CBHP project. One of the reasons could be because of CPHC's general policy to conduct evaluations only upon request of the programs themselves.

2) Another problem observed was that many good conference and consultation resolutions or plans remain on paper for lack of being followed up.

3) Perhaps with the growing number of CBHPs today and a more centralized system in the proposed new CBHP coordinating body, regular short-, medium-, and long-term planning targets can be mapped out on the local, provincial, regional, and even national levels, on such points as CBHP expansion areas, for example.

4) For greater efficiency in CPHC administration, perhaps a clearer delineation between the direct and indirect services of the four Secretariats can be made, while still working together, as was similarly suggested in one the earlier reports. For example, CPHC can put the Training,

Research and Communications Secretariats under a national services organization, while the Executive Secretariat (with slight modifications in membership) can handle direct CBHP coordination work.

5) For better information dissemination and service, a catalogue of training materials, modules, etc. currently available should be made, to be sent to CBHPs so they can request what they need or at least know what is available. There are probably enough materials by now to complete a catalogue.

6) A complete directory of all CBHPs in the Philippines (within and without of CPHC's network) should be made, containing updated basic information about each of them (e.g., nature, area of operation, thrusts and activities, etc.) In fact, this was a recommendation made as early as 1984 (in a document called "1984 Specific Stresses") but was not followed up. The Evaluation Reports, Area Visits, and Program Questionnaires could be useful for this. The idea of computerizing the data should also be considered.

7) Though a marked improvement in content and form is evident in Tambalan, the publication continues to be delayed. Maybe other sources of articles can be explored. Likewise, stricter measures in editing, production work, and meeting deadlines should probably be enforced.

8) A standardized format for the CPHC Progress Report should be developed to facilitate future evaluations, year-to-year comparisons, and the monitoring of activities. It should also be done on a regular basis (every six months is favorable), and in a more detailed form, if possible. The 1988 Report did not follow the usual format and tended to be too general in its information. In contrast, the 1983 assessments were reported well, and even laid down CPHC direction and orientation for the future. A similar suggestion should be made to local programs and agencies to develop a standardized format for their progress reports for easier future evaluation.

9) There is a need to help improve the traditional health care component of CBHPs by developing conveniently located herbal gardens; intensifying local and regional initiatives in research on herbal medicines and home nursing practices; and setting up cooperative pharmacies in the communities. CPHC may not be able to directly do any of these activities, but it can help out in its own way. For example, the Research Secretariat could collect information nationwide about the actual successful experiences of CHWs in practicing traditional medicine [e.g., use of acupressure for toothache, use of an herb (lagunde) for effectively curing asthma, cough, cold, fever, etc.], in order to better share information and allow CBHPs to learn from each other.

10) Since economics is probably the major cause of CHW and staff dropouts, a solution, though temporary it may be, should be found to alleviate the situation. Perhaps credit unions could be set up for CHWs and other CBHP workers. A common fund or rolling fund for CBHP agencies could also be devised so that this could help them out during difficult periods (e.g., delayed grants, in-between grants, national economic crisis, etc.)

Appendix A: Partial List of CPHC's Network Linkages, 1980-1989

Alamapa Health Program-Mindanao

Alay Kapwa Kilusang Pangkalusugan (AKAP)

Alliance of Health Workers (AHW) (Formerly Campaign for Nurses' Involvement)

Botanical Society, University of the Philippines

Bukluran para sa Kalusugan ng Sambayanan (BUKAS) (formerly Task Force for People's Health)

Center for International Health Concerns (CIHC-Philippines)

Center for People's Health Resources and Services (CPHRS-Iloilo City)

Center for Women's Resources (CWR)

Community Action for Training in Community Health (CATCH)

Community Based Health Program (Bacolod, Iloilo, Isabela, Zamboanga)

Community Based Health Services (CBHS-Mindanao)

Community Health Education Services and Training in the Cordillera Region (CHESTCORE)

Community Projects on Appropriate Technology for Health (CPATH)

Comprehensive Community Health Program, University of the Philippines (being phased out)

Council for People's Development

Department of Health (DOH)

Department of Labor and Employment (DOLE)

Department of Pharmacology, University of the Philippines, College of Medicine

Forum for Rural Concerns

GABRIELA

Health Action Information Network (HAIN)

Health Alliance for Democracy (HEAD)

Health Integrated Development Services (HIDS)

Health League for the People (HELP)

Health Research and Development Program (HRDP, Population Center Foundation)

Institute for Occupational Health and Safety (IOHSAD) (Formerly, Factory- Based Primary Health Care Program (FBPHCP)

Institute on Religion and Culture-Philippines

KAPPAG-Manila

KAPPS-Samar (Community Health Program of Samar)

KATIWALA-Mindanao

Kilusang Mayo Uno (KMU), Worker's Health Affairs Department

Lambatkaya Network for Participatory Development MAKAPAWA-Leyte

Medical Action Group (MAG)

Medical Mission Group-Davao

National Commission on Women (NCW)

National Ecumenical Health Concerns Committee (NEHCC-NCCP)

National Institute and Science and Technology (NIST)

National Science Development Board (NSDB)

National Science Research Center

PARUD

Philippine Nurses Association (PNA)

Philippine Rural Reconstruction Movement (PRRM)

Philippine Youth Health Program (PYHP)

Rural Missionaries of the Philippines Community Based Health Development Program (RM CBHDP)

Rural Health Practice Program (RHPP-DOH)

Social Action Center's Health Programs at the Diocesan Level

Society for the Advancement of Traditional Medicine (SATMED) (now defunct)

TABAK

Teaching and Educational Assistance for Community Health (TEACH- Cebu/Bohol)

Third World Studies Center, University of the Philippines

Urban Integrated Health Services-Mindanao

Visayas Primary Health Services (VPHS)

APPENDIX B. TAMBALAN ARTICLE STATUS CHART

ARTICLE	AUTHOR	DATE IN	EDITING	RE W/T	TS	CORR	PR	LO	REMARKS
Editorial									
Cover Story									
Review of Folk Medicine									
How-To									
Feature									
Tales from the Grassroots									
PHC Elements									
Readers' Series									
Updates									
Tulatbp.									
Solidarity/ Friends of CPHC									

Appendix C: List of CPHC Progress Report

	Progress Report for Period		Number of Months Covered by Report
	From	To	
1.	January 15	May 15, 1980	4
2.	May 16	July 15, 1980	2
3.	July 16	October 15, 1980	3
4.	October 16, 1980	January 15, 1981	3
5.	April 16	August 31, 1981	4 1/2
6.	September 1	April 30, 1982	8
7.	1980	1983 (4-yr. assessment)	48
8.	January 1	June 30, 1983	6
9.	July 1	December 31, 1983	6
10.	January	December 1983	12
11.	January 1	June 30, 1984	6
12.	July 1	December 31, 1984	6
13.	January	June 1985	6
14.	July	December 1985	6
15.	January	December 1986	12
16.	January	March 1987	3
17.	April	December 1987	9
18.	January	December 1988	12

Notes:

1) Report for period January 16, 1981 to April 16, 1981 is not available.

2) According to the Executive Director, no report has yet been prepared for 1989.

Appendix D: List of CPHC Training Materials as of April 1989

I. Slides

Kuwento ni Rosario

Symptoms of Decay

Drug Industry

What is PHC

Pepe and Pilar

PHC Strategies

Recognize the Disease

Health in the Cordilleras

Medicinal Plants

Hypertension

Diarrhea

More about Childcare

Learning to Draw and Use Pictures

Synapsis and Receptors

T-Lymphocites Fighting Cancer Cells

Grastroduodenal Aspects

II. Flip Charts

Chain of Cases

PHC Docupictures

How to Play the Nat Biop

When your Child is Sick

Prevention of Diarrhea

Scabies

Prevention of Different Diseases

Rehydration Solution

III. Handouts, Transparencies, Manila Paper

Paraan ng Paggawa ng Karayom (Training Demonstration Material)

PHC Campaign Materials

US Bases Reading Materials

First Aid During MAS

Papers on Disaster

Community Diagnosis

Reading Materials for Population Education

National Drug Use (Training Kits, Pharmacotherepautics, Drug Industry

Chart, Fact Sheet on Use of Drugs, Posters)

Training Kits(T.L.S.Principle-Training Evaluation,Teaching
Methodology I and II, Training Process, Overview of CBHP Training,

Community Analysis, Training Paper, Communications Training,

Curriculum Design, Task Analysis)

Resolution Training Consul (Questionnaire, Task Analysis, Teaching

Strategies for PHC)

Materials for Community Health Workers of Samar/Leyte

Waray Handouts (ABC)

Nutrition Bingo

Action Songs

Common Diseases (Tagalog-English Handouts, Expanded Program on

Immunization)

First Aid Training Materials (Tagalog-English Handout on Sanitation

and Personal Hygiene

Herbal Medicine

Anatomy and Physiology

U.F.C.

IV. Charts:

T.L.S.

Nutrition

National Situation

Community Organizing

Training Consultation Working Paper

Acupressure Training Materials

Concepts of Health Diseases

Moxibustion/Ventosa

V. Cloth

Anatomy (T-shirt and Puppets)

Common Diseases

Wastong Paraan ng Pagbubuhat

Bandages (Triangular, Rectangular, Long, Double Triangle)

Acupressure

Acupuncture

Respiratory Anatomy

First Aid

VI. Posters

U.F.C.

Political Detainees

Diarrhea

CBHP Objectives

First Aid

Health of the Nation in Crisis

Common Diseases and Herbal Treatment

Digestive System

Diarrhea Treatment

Acupressure

Nutrition

Malaria

Dental Care

Neonatal Tetanus Prevention

Normal Menstrual Flow Herbal Medicine

Mission Statement of the Healing Ministry

Contraceptive Method

Appendix E: List of Research Instruments Developed and Used by the Research Secretariat

1. General Guidelines for Evaluation at the Community Level 2. General Guidelines for Evaluation of the Program Staff 3. (General Guidelines for Evaluation of) Program Management 4. Guidelines for Area Visits 5. (Guidelines for) CPHC Area Visits 6. CHW Interview Guide (Form #3) 7. Leader's Interviewer Guide (Form #4) 8. Program Questionnaire (Form #5)

Appendix F: List Of CPHC Publications

Tambalan Newsletter (Quarterly)

First Issue: September 1979 (No. 1)

Latest Issue: July-September 1988 (No. 47)

Primary Health Care Readers' Series (PHCRS), Partial List PHCRS No. 2, "Science, Technology and Social Structure in the Development Process," 29 p.

PHCRS No. 3, "Hospital Workers: A Case Study"

PHCRS No. 4, "Primer on the Philippine Drug Industry"

PHCRS No. 5, "Peri-Urban Malnutrition, A Neglected Problem: Patterns and Approaches"

Jan.-Feb. 1981, "Appropriate Technology in Health"

Mar.-Apr. 1981, "Primer on the Drug Industry"

May-June 1981, "Health Care and Human Dignity: A Subjective Look at Community-Based Rural Health Programs in Latin America," David Werner, 19 p.

July-Aug. 1981, "Creating Critical Awareness in Health: Applications of Freire's Philosophy and Methods to the Health Care Setting," Meredith Winkler and Kathleen Cox, 5 p.

Sept.-Oct. 1981, "Developing Traditional Medicine through a Community-Based Approach," Michael L. Tan, 5 p.

Nov.-Dec. 1981, "The State of the Philippine Drug Industry," Nelia Cortes-Maramba, M.D., 3 p.

Jan.-Feb. 1982, "A Physician Cries Out: The Non-System of Health Care for the Urban Poor," Jarelle Goetcheus, 7 p.

Mar.-Apr. 1982, "Health Care by the People (Primary Health Care)," Mita Pardo de Tavera, M.D., 4 p.

May-June 1982, "Tuberculosis in Children in Developing Countries," MitaPardo de Tavera, M.D., 5 p.

July-Aug. 1982, "Treatment of Acute Diarrhoea with Oral Rehydration Solution," David A. Sack, 9 p.

Sept.-Oct. 1982, "Warning: The Philippine Economy Now Nearing Comatose," Roan Libarios, 6 p.

Now.-Dec. 1982, "People's Participation: A Basic Human Right," Dr. Dioscoro Umali, 9 p.

Jan.-Feb. 1983, "Looking Into the Politics of Health," Pennie A. dela Cruz, 8 p.

Mar.-Apr. 1983, "Working as Equals: Towards a Community-Based Evaluation System," Maureen Pagaduan and Elmer M. Ferrer, 13 p.

May-June 1983, "Participatory Strategies in Community Health," Jaime Galvez-Tan, M.D., 10 p.

July-Aug. 1983, "Health for All: Everyone's Concern," Dr. Halldan Makker, 4 p.

Sept.-Oct. 1983, "Getting Down to Basics," William A. M. Cutting, 6 p.

Nov.-Dec. 1983, "People's Participation according to Development Agencies:

Myth or Reality," Alex Apit, 10 p.

Jan.-Feb. 1984, "Schema for Evaluating Community Health Programs," Carolina P. Araullo, M.D., 5 p.

Mar.-Apr. 1984, "Medicine and Social Responsibility," Roland Simbulan, 4 p.

May-June 1984, "Primary Health Care: Another Placebo?," Michael L. Tan, D.V.M., 3 p.

July-Aug. 1984, "Community Organization and People's Participation," Karina C. David, 12 p.

Sept.-Oct. 1984, "Alternatives in Health Care," Carolina P. Araullo, M.D., 4 p.

Nov.-Dec. 1984, "The Story of Chelo," David Werner, 4 p.

Jan.-Feb. 1985, "Hazards and Potentials of Self-Medication: An Example from a Filipino Village," Anita Hardon and Sjaak van der Geest, 10 p.

Mar.-Apr. 1985, "Filipino First, Doctors Second," Jaime Galvez-Tan, M.D., 10 p.

July-Aug. 1985, "Primary Health Care as a Social Development Strategy: A Focus on People's Participation," Minda Luz M. Quesada, 12 p.

Sept.-Oct. 1985, "CBHP's: Making History Slowly But Surely," TAMBALAN Staff, 10 p.

Nov.-Dec. 1985, "Advancing the People's Struggle Through Alternative Program in Health," Gerardo P. Andamo, 6 p.

Jan.-Feb. 1986, Reducing Reliance on Institutionalized Medicine," Derek Hall, 8 p.

Mar.-Apr. 1986, "Primary Health Care and Indigenous Medicine," Michael L. Tan, 6 p.

May-June 1986, "Making the Community Diagnosis," Helen Gideon, 10 p.

July-Aug. 1986, "Does Your Teaching Resist Change, or Encourage It?," David Werner and Bill Bower, 6 p.

Sept.-Oct. 1986, "Disabled Village Children - Part of Primary Health," David Werner and the Hesperian Foundation, 10 p.

Nov.-Dec. 1986, "Who Killed Rosario?," Michael L. Tan, 4 p.

Jan.-Feb. 1986, "Safety at Work"

Mar.-Apr. 1986, "People's Initiatives in Providing Services," Gerardo P. Andamo, 10 p.

May-June 1986, "Community Communications," Virgilio Labrador, 10 p.

July-Aug. 1986, "Treating Mental Illness in the Community," Dr. Akolawole

Sept.-Oct. 1986, "Readings on Rational Drug Use," Compiled by the TAMBALAN Staff, 16 p.

Nov.-Dec. 1986, "Role of Research in Community-Based Health Programs and Some Readings," Michael L. Tan, 17 p.

Training Manual on PHC in English and Pilipino, July 1980

Acupuncture Needle-Making Manual (in Pilipino), July 1980

Manual on Medicinal Plants (in Pilipino)

Manual for Community Health Workers (in English and 3 Dialects)

Trainor's Training Manual

Botika sa Ating Kapaligiran, 2nd. Ed., 1981

Trainee's Guide to Acupuncture

Trainor's Guide on First Aid/Unang Lunas, 89 p.

Botika sa Baryo

Caring Enough to Care: Diagnosing the Disease-Poverty Syndrome, CPHC Editorial Board, 1986, ix, 122 p.

Unmasking the Textile Industry: A Report on the Health Problems of the Textile Workers in the Philippines, CPHC Health and Workers Group, 1985.

CPHC Research Series (CPHCRS)

Ventosa/Ventusa, Rev. Ed., January 1987, 11 p.

Moxibustion/Moksibasyon, Rev. Ed., 1987, 18 p.

Herbal Medicine/Mga Halamang Gamot, Rev. Ed., 1987, 22 p.

Simple Microscopy (Uses and Care), 37 p.

Urinalysis

Simple Stool Analysis (Fecalysis), 1985, 21 p.

Hematology

Acupressure, CPHC Ed., 2nd Printing, 44 p.

Traditional Herbal Medicine/Katutubong Halamang Gamot, Rev. Ed., Jan. 1987, 29 p.

Appendix G: List of Financial and Accounting Forms Used by CPHC

1. Petty Cash Voucher
2. Cash Voucher
3. Journal Voucher
4. Reimbursement Report
5. Liquidation Report
6. Budget Request Form

The Community-Based Health Services, Inc.:

A Case Study

by

Manuel P. Diaz

Introduction

As of the middle of 1989, the Community Based Health Services (CBHS), whose principal offices are located in Davao City, had established community-based health programs (CBHPs) in ten dioceses covering some thirteen provinces of Mindanao. The organization's programs are found in 103 parishes and municipalities, providing much-needed health and other related services to 911 barangays through some 2,309 active front line community health workers (CHWs). These figures perhaps make the CBHS the largest non-government organizations (NGO) in the Philippines whose approach to health care delivery is anchored on the community-based method.

This case study of the CBHS traces the growth, expansion, and changing strategies of the organization and its programs beginning with the pilot areas initiated by the Sisters of the Rural Missionaries (RM) in Iligan Norte in 1975 to the present. It also describes and provides an assessment of the philosophies and principles that guide the CBHS' operations and the objectives of the organization. This necessitates detailing various aspects of the organization and its operations including its services, its program administration and financial management, and the major problems it has encountered in the past and at present. The description and analysis of these are used in assessing the organizational and technical strengths and weaknesses of CBHS, as well as the relevance and appropriateness of its thrusts and orientation. These, in turn, form the basis for the study's concluding observations and recommendations.

The case study is based on information culled from an extensive reading of reports, records, documents, and publications. Interviews were also conducted with past and present program officers at all levels of the organization, and with CHWs and other non-CBHP health and non-health professionals. Finally, some visits were made to a number of CBHS program areas to observe their activities.

A more comprehensive assessment of the CBHS would have required a more detailed investigation of each of the above- mentioned aspects of the organization. However, owing to a number of constraints, this was not possible. First, due to the size of the organization and the magnitude of its operations, and to time and resource limitations, only a number of program areas could be visited. Thus, only conditions obtaining in these, which may not be typical of all areas, are described in the report. Secondly, former officers and personnel who could have provided valuable information on, for example, the development of community-based health programs in Mindanao and on CBHS's own history could not be located for interview. Finally, not all important documents required for a comprehensive review were available, and quantitative and other kinds of information were not consistently recorded (or were recorded in various formats) making longitudinal comparisons difficult to make. Sufficient information, however, was gathered that permits at least the broad description of the various dimensions of the organization, and for drawing some conclusions on, and recommendations for the CBHS community-based health program.

Philosophy, Objectives, and Strategies

CBHS shares with the Community-based Health Development Program (CBHDP) of the RM (discussed in the preceding case study) and other NGOs engaged in community-based health programs similar guiding philosophies, general objectives, as well as basic strategies. Central to this philosophy is the belief that health is a fundamental human right and a social goal and responsibility. Moreover, health problems are seen as interrelated with, contribute to, and are heavily influenced and affected by the larger social, economic, political and cultural problems of society. As such, the solution to health problems largely rests and depends on the overall transformation of society as a whole.

Consequently, the strategy adopted for solving health problems is to simultaneously address the other societal problems with which health is directly related and inextricably linked. Thus, the approach emphasizes that programs include activities which would:

1) distribute health resources according to the needs of the majority;

2) foster self-reliant projects such as herbal gardens, *botika sa barrio*, and those that generate income;

3) develop appropriate technology and promote the use of local resources both human and material; and

4) continuously develop the capability of CHWs to provide the primary health care needs of the people.

The approach is also characterized by what proponents call its preferential option for the poor - that is, CBHS concentrates its efforts on the lower 30% of the Philippine socioeconomic hierarchy. The CBHS approach also encourages respect for and promotion of indigenous and traditional medicine; a focus on health education and promotive and preventive medicine; and the building of awareness regarding the relationship of health with sanitation. Finally, in the words of one informant, the community-based approach to health is "mass-based, non-elitist, nationalist, and scientific."

People's participation in health-related decision-making, planning, implementation, and evaluation is also central to this approach, as is the collective sharing of responsibility for the community's health needs. Community health workers who are elected and supported by the people are preferred, and organizations that are chosen by and which serve the people's needs are those that are encouraged to be formed. The underlying premise, therefore, is that the solution to health problems can be attained through the involvement of the people themselves in planning, implementing, and evaluating their own health program; the promotion and use of indigenous resources; the promotion of commitment to service rather than a profit orientation; continuing health education that is widespread and non-elitist; the development and strengthening of awareness raising activities; and people's participation in organizations and mobilization campaigns.

Based on the above philosophy and corresponding strategies, CBHS identifies its ultimate objective as the promotion of self- reliant health care in the context of holistic and integrated development. To this end, the organization has set for itself the following general objectives:

1) to increase the awareness of people of their situation where structures prevent the attainment of basic health care and other human needs;

2) to maximize the participation of people in decision- making in health and all aspects which affects their lives;

3) to organize community action to solve their own health and other problems; and

4) to promote self-reliance in health care and other aspects of their lives to the extent of their resources.

To attain these objectives, the identified activities of the community-based health program are:

1) the training of community health workers who are elected by the community in basic and advanced health care and enable them to provide voluntary health care in their own community;

2) the launching of public health campaigns such as sanitation, immunization, potable water, control of communicable diseases and maternal and child health care;

3) the provision of basic health care services and clinics at the village level and access to secondary and tertiary health care through referral systems;

4) the promotion and use of Filipino traditional medicine; and

5) the publication of health manuals in the vernacular.

History

Background: 1975 - 1982

Although the CBHS was not established and registered as a corporation with the Securities and Exchange Commission (SEC) until 1983, its roots can be traced to the pilot areas established by a Health Team (HT) headed by the Program Coordinator, Sr. Nanette Berentsen of the Rural Missionaries of the Philippines (RM), in the Diocese of Iligan in Lala, Lanao del Norte. The RM Health Team's major activity was the conduct of extensive seminars to introduce and propagate the

program's orientation and philosophy particularly among church officials and workers. To prepare for the anticipated expansion of the program, the Health Team also popularized the CBHP approach among health professionals, priests and sisters, and initiated linkages with hospitals, clinics, and municipal health physicians in different areas of Mindanao. In addition, through brief skills training sessions and seminars, members of the Team assisted and trained, the program staff in conducting community meetings in the barangays, and in raising people's awareness of their responsibility towards their own health and in identifying and selecting their own health workers. A manual for CHWs and a guide for trainors served as the basic text for the popularization of the program and the training of CHWs.

As a result of the efforts of the RM Health Team, the community-based approach to health had gained sufficient following by the end of 1975, so that in August 1976, the church- based Mindanao-Sulu Secretariat for Social Action (MISSSA) in coordination with the RM sponsored a conference for the staff members of the Health and Nutrition Program of the different dioceses in Mindanao to acquaint a wider audience with the community-based health program. At the same time, in response to increasing demands for their services, the RM divided responsibilities among themselves, with Sr. Xavier de Marie Bual, SPC assigned to respond to requests for initiating community-based health programs in other dioceses in the Visayas and Mindanao.

Shortly after the MISSSA-sponsored conference, community- based health programs were started in the Prelature of Malaybalay in Bukidnon, in Oroquieta in Ozamis, and in Tangub. The program in Oroquieta, however, did not take root because of lack of interest and support from some of the priests in the diocese. (This occurred in spite of the policy of the RM to establish programs only in those parishes whose priests showed interest in, and willingness to support such a program.) Contributing to the program's failure in Oroquieta was the deteriorating peace and order situation and increasing militarization of the area. The program in Tangub, on the other hand, lasted only for three months because the priest who helped begin the program was replaced by one who was not particularly interested in this and whose priorities were on other church programs.

The program encountered other difficulties during this period. Alinsky's principles and methods of community organizing (CO) which were used in propagating the community-based health program's orientation and philosophy drew negative reactions from many church people. Although these principles and methods resulted in the fusion of structural analysis and community organizing, the approach was viewed by many as "confrontational and issue-oriented" and failed to sufficiently relate health problems and issues to the over-all societal situation. This issue-oriented approach, in turn, "stunted the level of consciousness" of the religious, the program staff and workers, and the CHWs. And although many CHWs were trained during the period, "the selection process was poor."

In 1977, a refined community organizing strategy for health development, the use of health services as an entry point for organizing communities, was introduced. A CBHP was established in the Diocese of Marbel also in 1977. In August of the same year, the Mindanao-Sulu Pastoral Conference Secretariat (MSPC) and MISSSA saw the need for and subsequently established a CBHP Health Desk that would administer the program since its coverage had expanded rapidly, being already in place in three dioceses.

In 1978, community-based health programs were started in the Dioceses of Tagum and Butuan. In the same year, an Annual Conference was convened by the MISSSA-CBHP Desk. One of the major decisions reached during the conference was the creation of a CBHP Board which can more adequately respond to the needs of the program by having as member, a Regional Trainor tasked with providing continuing education to the staff and advanced CHWs of the program. Dr. Manolet Dayrit, now with the Department of Health, was elected Chairman and Program Coordinator.

The year 1979 was marked by important events. Program coverage further expanded with the establishment of programs in Cagayan de Oro. It was also in 1979 when the CBHP Board formally took over the functions of the MSPC-MISSSA Health Desk, and a new Program Coordinator (Romy Lagahit) was elected. More significantly, the CBHP Board received a three-year assistance grant from Misereor to support the program's activities in ten dioceses in Mindanao.

With the program now in place in seven dioceses, the Annual Conference held in August 1979 concentrated on the evaluation of earlier activities and on detailing the activities to be undertaken in the next several years. The discussions at the Conference revealed that among the program's accomplishments were assistance rendered in assisting peasant organizing and the use of social investigation for providing data for community organizing and the proper selection of CHWs. It was the consensus that the shift in the approach to community organizing played a major role in the rapid expansion of CBHPs. However, it was also felt that the CBHP staff still "did not have a firm grasp of the CBHP orientation which affected methods of work." Moreover, "while there was leveling off in the understanding of the nature of the program, some members of the Board did not accept the CO component and consequently discredited it." Finally, according to a CBHS document, it was perceived that "there was an imbalance between the organizing work and the health component of the program which also created suspicion on the nature of the program and the political leanings of the CBHP personnel. The conscienticized CHWs, the staff and the organized communities threatened the traditional church leadership."

These findings led to a shift in CBHP's orientation in 1980 from community organizing to limited health sector organizing, thus giving importance to the program's health component. Health issues were used as a springboard for discussions of general political issues as was done during the Werner Symposium held in Davao in November 1981 which attracted an audience of around 600 people, mostly health professionals.

In 1980, the program in Ozamis was discontinued again due to lack of interest and support from the parish priests and "internal difficulties." The major cause was the inability of the CBHP Board to interfere directly with the internal affairs of the Diocese even on matters that directly concerned the health program. The CBHP experienced other problems at this time, including the resignation of the Program Coordinator. With no one to provide direction, the staff concentrated on routine activities and no annual conference was held. One was held in 1981, however, and a new Program Coordinator (Ms. Ethel Apuzen) assumed the position later that year. The area coverage expanded rapidly during the year with the introduction of the program in two more dioceses: Dipolog, and Ipil.

Another development occurred in late 1981 which was the establishment of Health and Development-Mindanao (H and D), an affiliate of the MISSSA CBHP which was envisioned to establish,

coordinate, and assist non-sectarian community-based health programs. Specifically, H and D's objectives were to:

1) work with organized communities to help them design, implement, manage and evaluate their own community-based health program;

2) train individuals selected by their community in primary health care;

3) make primary and secondary health care accessible and available to the people within the program areas;

4) research, propagate and utilize scientific traditional health resources, e.g., traditional healers, medicinal plants;

5) form community self-help groups that would function in socio- economic health activities; and

6) provide opportunities for interested students and professionals who request exposure to community-based health programs.

H and D worked in pilot areas in four provinces (Surigao del Sur, Agusan del Norte, Agusan del Sur, and Cotabato) and in Davao City. (When H and D was absorbed by CBHS in 1987, these programs came under the latter's network and supervision.)

Although H and D was organizationally independent of, it worked closely with, CBHP. Its physical proximity to the CBHP offices (in the same building), contributed to H and D's accessibility to CBHP and therefore benefited from, in the words of one informant, its "high level of technical expertise. H and D was particularly strong in the development of training materials for CHWs and in staff development." Informants give much credit for the valuable assistance rendered by H and D to CBHP to the efforts of Dr. Jaime G. Tan, H and D's first Program Coordinator, and those of his wife, a nurse, who also worked with H and D.

Finally, in October 1981, the First Mindanao-wide CHW convention was held in Butuan City. Attended by CHWs, program staff members, and national and foreign guests, the Convention aimed to address the increasing difficulties that CHWs were experiencing such as harassment by military and the lack of financial support. One major resolution passed by the CHWs was to organize themselves at the parish, diocesan, and Mindanao-wide levels. (This and other CHW-related issues is discussed more fully in a separate section below.)

In March 1982, discussions began on establishing a CBHP organization independent of the MSPC and MISSSA. These discussions came at the height of the conflict between the Mindanao Bishops and the Board of Directors and staff of both the MISSSA and MSPC. The conflict eventually led to the dissociation of the Bishops from the MSPC, and the separation of MISSSA from MSPC. CBHP was directly affected by the conflict as it was a Desk of MISSSA. Within CBHP itself, there was an increasing need felt for such an independent organization as MISSSA could only provide support for one member of the, rather than the entire, staff of three who attended to the program. Among the other factors that were considered in arriving at this decision was the accusation that

the CBHP was "infiltrated by radical elements" and that "CBHP personnel had links with subversives." "It was becoming extremely difficult to work under this cloud of suspicion," complained one informant. The issue of salaries was also a key factor. The higher rates of the CBHP paid its staff members was apparently "envied" by those in the other programs resulting in low staff morale in these other programs. Finally, the staff members of CBHP were displeased with the practice of "lumping the funds for the health program into a common fund from which all Church programs could draw." As one informant said, "since the MISEREOR subsidy was specifically granted to support the health program, the funds should only be for its exclusive use. For these reasons, the Assembly, with the support of the then Bishops of the Dioceses of Kidapawan, Tandag, Surigao Sur,, and Butuan, voted to establish an organization which could fully respond to the needs and demands of the program. Thus, in February 1983 the Community Based Health Services, Inc. was established and the members of its first Board of Directors were chosen in July that year.

1983-1985: Institution-building and Consolidation

The programs in Tandag and Kidapawan were initiated in 1982, making them the ninth and tenth dioceses in the network of the newly-formed Community-Based Health Services Mindanao Association, Inc. (CBHS). No new diocesan programs were organized by CBHS since it became independent of MISSSA, although Tagum's was split into two with the creation of the Diocese of Mati in 1986. Programs at the parish and barangay levels, however, continued to expand, termed by proponents "internal expansion." Thus, as of December 31, 1985, 99 parishes had community-based health programs in place, involving some 1,375 Gagmay Kristiyanong Katilingbans (GKKs). By this time also, 4,517 CHWs had been trained, although only 2,334 (less than 52%) were active.

It is interesting to note that the year CBHS was founded, 1983, coincided with an equally important event in Philippine society - the assassination of former Senator Benigno Aquino which ushered the Philippines into a new, albeit uncertain, period that lasted until 1986 with the departure of Ferdinand Marcos and the installation of Aquino's widow as President of the Republic. Thus, mirroring developments in Philippine society, the community-based health approach in Mindanao entered a new phase in its history.

During the period under consideration, CBHS focused its efforts on strengthening the capabilities of its staff and their capacity to meet the new challenges through training in special skills such as program management, and by consolidating the gains from the region-wide expansion of the community-based health program since 1975. This consolidation involved the upgrading of the CHWs' leadership and knowledge and skills and attitudes toward health; the formation of CHW organizations at various levels (Mindanao-wide, Diocesan, and Parish); and by pursuing networking activities with health professionals supportive of the goals of the community-based health program. These thrusts and orientation were identified based on the results of an assessment that preceded the Staff Conference held in July 1983 which was convened to evaluate CBHPs in Mindanao, standardize the training curriculum, and to discuss basic research as well as identify the research needs of the programs.

A resolution was also passed during Conference to register the organization with the Securities and Exchange Commission. In addition, new members of the Board of Directors were elected which included four representatives from the diocesan programs, a representative of the RM, and a Bishop. Completing the seven-person Board was the CBHS Program Coordinator who serves as ex-officio member.

In line with the thrusts identified for the period, administrative capabilities of the staff at all levels were strengthened through skills training activities in Financial Management, Facilitating and Leadership, Program Management and Library Usage and Enneagram in coordination with H and D. Research skills were developed when CBHS co-sponsored the National Conference on Participatory Evaluation held in Cebu in July 1984. Representatives from all of the diocesan programs and several CHWs attended the conference and later held "echo" seminars in their respective areas to share their newly-acquired knowledge. A direct result of the staff development activities was the "systematization of CBHS operations." Job descriptions were reviewed , clarified and redefined. The line functions of the Secretariat were also delineated and staff meetings were regularized to facilitate monitoring and follow-up of program implementation.

In the area of upgrading the health skills of both program staff and CHWs, training activities in advanced topics such as Microscopy, Dentistry, Minor Surgery, Advanced First Aid, Laboratory Procedures, Basic Pharmacology, Acupuncture II, Blood Typing and Oriental Medicine were also conducted in close coordination with H and D. In addition, trainings in Teaching, Learning, and Communications were also held for selected CHWs to prepare them to become trainors themselves.

One of the notable gains of the period was in the area of health sector organizing. This activity was initiated in March 1983 when H and D co-sponsored a Mindanao-wide convention of health professionals and paramedical workers with the theme "Health Perspectives in the 80s." The convention resulted in the formation of the Health Alliance of Mindanao (HEAL) with an Ad Hoc Council which immediately passed a resolution to register the newly-formed organization with the Securities and Exchange Commission. Later that year, HEAL sponsored a conference on Medicine and the Law attended by some 200 health professionals and students.

By the end of 1985, HEAL had held a second Mindanao convention attended by over 100 professionals, students, and CHWs with the theme "Health of the Nation in Crisis: The People's Response." It was during this convention that HEAL's own constitution and by laws were ratified, its declaration of principles drafted, and its Board and Executive Committee elected.

As of the end of 1985, HEAL chapters had been formed in South Cotabato, Agusan-Surigao, Davao City, Davao del Norte-Davao Oriental, Dipolog, and Cagayan de Oro. The first issue of the organization's publication, HEAL Gazette, was also released with the proceedings of the conference on Law and Medicine.

Although HEAL was an organization independent of both CBHS and H and D, the two latter organizations played major roles in constituting and later, in administering HEAL. H and D staff members initially served as the organization's secretariat and subsequently assisted HEAL in form-

ing its own secretariat. An H and D staff member was requested to join HEAL's secretariat and to help oversee the implementation of HEAL's programs.

Another significant gain of the period was the expansion of both CBHS' and H and D's alliance with other organizations and the intensification of their exposure program. Linkages and alliances were initiated or were maintained with the Rural Missionaries Health Team, the Council for Primary Health Care, the National Ecumenical Health Concerns Committee of the NCCP, the Christian Medical Commission of the WCC, and professional associations such as the Philippine Nurses Association and the Philippine Medical Association.

The exposure program, initiated in 1982 by H and D and the then MISSSA-CBHP, aimed to "influence health students" whose training was deemed not geared towards community service. Under this scheme, health students would stay for a few weeks in the communities where CBHP and H and D have community-based health programs. They were expected to work closely with the CBHP staff members, integrate with the people, and participate in the activities of the CHWs. In 1984, the program drew eight individuals including two nurses, a member of the staff of the newly-established CBHS, and five students of medicine and medical technology.

In the assessment of CBHS and H and D staff members, the period between 1983 and 1985 was hen the services and programs of both institutions developed further, the CHW organizations grew, nd health sector organizing flourished. In cooperation, CBHS and H and D developed new forms f educational and communication materials such as brochures, and sound- and visual slides. Both trengthened their linkages and alliances through inter-agency coordination, by writing letters of upport, making public statements on their stand on issues of national and regional importance, and by supporting mass mobilizations through financial contributions and active participation. They also began to offer additional services such as a library and the H and D's data bank. International relations work was also started through contact building, whereas the student exposure program was moving towards the desired direction of raising the social consciousness of students through rural integration. Internally, management procedures were simplified and operations systematized through new program and financial policies.

1986-1988

Towards the latter part of 1985, it was increasingly felt that the community-based health program's experience which had been in existence since 1975 had to be assessed. In the case of Mindanao, no Conference had been held since July 1983, and the expansion and rapidly changing course of events that affected the program demanded "taking stock." Thus, an "in-depth evaluation" was conducted to assess the program's development specifically between 1983 and mid-1986, identify strengths and weaknesses, derive lessons from the experience, and identify program thrusts for coming years.

It is again interesting to note that the assessment which would usher the community-based health program under CBHS into a new period coincided with an equally important event in the Philippine national scene - the installation of a new Philippine President, Corazon C. Aquino.

As a preparation for the Mindanao-wide assessment, an in- depth evaluation of the ten diocesan health programs was conducted in May and June 1986. The evaluation format was prepared by the staff members of the CBHS Central Office with the assistance of H and D. The staff members of the Central Office also conducted the evaluation of the diocesan programs while the personnel of H and D supervised the evaluation of the parish programs.

The results of the assessment of the diocesan and parish programs became the basis for the regional assessment held during the Staff Conference held for six days in July 1986 and attended by 62 participants including 45 members of the ten diocesan programs. Its specific objectives were to:

1) unite on a common understanding of the present Philippine and health situation and its effect on the people;

2) assess the program's development from 1983 to mid-1986;

3) derive lessons and trends in the program's development; and

4) determine the thrust of the program for the coming years.

In the conference workshops, participants noted the many accomplishments (outlined above) in program implementation between 1983 and mid-1986. They also identified, however, many weaknesses, among which are:

1) requests for services and trainings in the program areas were not adequately met;

2) new forms of services were not fully availed of due to lack of promotion;

3) international linkages were not maintained and although policies on the exposure program had been formulated, these had not been circulated;

4) alliance work with health agencies both government and NGO in Davao was weak;

5) involvement in sectoral and multisectoral mass moblizations had been minimal;

6) only four of the seven HEAL chapters were active;

7) in the area of network building, there was a lack of "trouble shooting" and the system of monitoring and follow-up was weak; and

8) the staff members at all levels of the organization assumed multiple functions while the Board of Directors was "still non- functional."

After identifying the strengths and weaknesses of the program's various components, program management and other aspects, it was decided that the program's basic thrust for 1986- 1988 would be the continued consolidation and systematization of all aspects of work. Identified as needing particular attention were the:

1) consolidation of basic skills and developing advanced skills;

2) consolidation and development, for those in the advanced levels of the program, to higher levels of skills needed to (provide) a higher level of health service;

3) consolidation/systematization and improving the capabilities of the organizations from the barrio to the diocesan levels, skills in organization and management and systems follow-up; and

4) deepening of the understanding of the philosophy and orientation of the community-based health program.

In line with these, the Central Office reviewed and prepared revised administrative and finance policies in consultation with the Program Coordinators. These policies were immediately implemented at the Central Office and adopted with modifications, to suit their particular needs and situation, by the diocesan and parish programs. Among these innovations was the institutionalization of individual monthly reporting using an individual monthly report form which aimed to facilitate the monitoring of personnel. The quarterly diocesan reporting was also improved through the use of a revised reporting form and to strengthen fiscal management, a Mindanao-wide finance management training was conducted for the Coordinators and Finance Officers of the diocesan programs. A result of the training was the adoption of a single system of finance management which, in turn, was reported to have facilitated reporting and auditing. Finally, a new body, the Advisory Council, was agreed to be formed, although it has yet to be constituted. This Council was to be composed of multi-sectoral representatives of doctors, bishops, labor, and women which would assist the Board in "objectifying discussions, foster coordination and support among sectors and assist in promoting the program."

Tasked with implementing activities that would achieve the other objectives identified by the participants at the Conference were the different Desks of the Central Office. These are detailed in the discussion of the Desks below.

1989

The thrusts identified during the 1986 Staff Conference also became the basis for the preparation of a project proposal which was submitted to a consortium of funding agencies. CBHS' fund grants were to be exhausted by 1986 and fresh financial support had to be obtained for the program's activities after 1986. This financial assistance which was expected to underwrite program activities for a three-year period beginning in late 1988 had, as of November 1989, not been totally approved by funding agencies, placing the organization in extreme financial difficulties (to be discussed more fully in a separate section below). In the meantime, the thrusts identified for the preceding period, 1986- 1988, needed to be reviewed to assess whether activities undertaken still fell within the defined overall direction and whether they were still relevant to the present situation. Thus, a Staff Conference was held in October 1988 to review the existing CBHP philosophy in the light of program

implementation and to define the thrusts of the program for the period beginning 1989 in the context of the national and local health situation.

One of the more important findings of the Conference concerned the effects of the "total war strategy" of the national government in many program areas. One of these was that many people's organizations had to disband or were paralyzed. Another was the forced evacuation of whole communities due to military operations.

In the light of these findings, the most important thrusts identified were:

1) health organizing or assistance in facilitating the establishment of people's organizations in unorganized or "recovery" areas; and

2) the continued provision of training and health services in organized areas.

As CBHS awaits the financial support necessary to underwrite the activities based on these thrusts, its staff is stretching its still available resources to fulfill their commitment of service to the people.

Organizational Structure and Program Management

Organizational Structure

With slight modifications, the organizational structure of CBHS has remained substantially the same as it was when the organization was established in 1983. (Refer to Charts 1 and 2.) According to the organization's by laws, the Members of the CBHS Association, Inc. are the program coordinators, program staff, office staff and volunteer Filipinos working with the program including CHWs. Other individuals who have unselfishly contributed to the pursuit of the corporation's objectives can be awarded honorary membership. No one has, however, been awarded such honorary membership.

The Assembly is the organization's highest policy- and decision-making body. The Assembly's participants come from among the staff of the diocesan programs and the Central CBHS Office in Davao. (This is known as the Regional Office, but as the term implies the existence of other regional offices, in this report it will be referred to as Central Office.) The number of participants to the Assembly is determined by the Board of Directors based on the size of the diocesan program (and the amount of funds available for holding the assembly). At the most recent Assembly, for example, large diocesan programs were allotted four participants while the Central Office elected three representatives. At least one of the Diocesan/Provincial representatives to the Assembly is a CHW, elected from among themselves.

Chart 1: Organizational Chart of the CBHS, 1983-1986

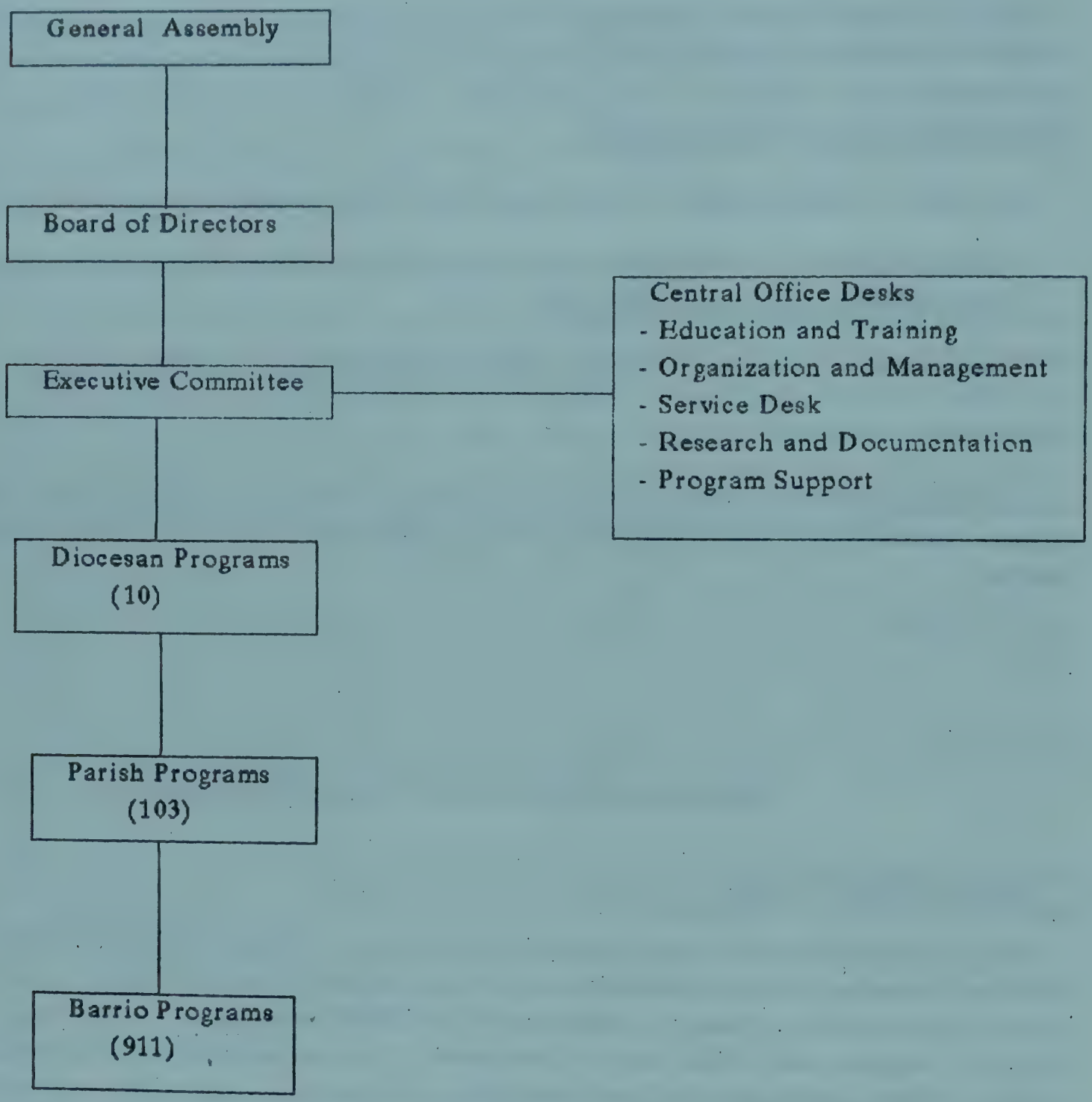
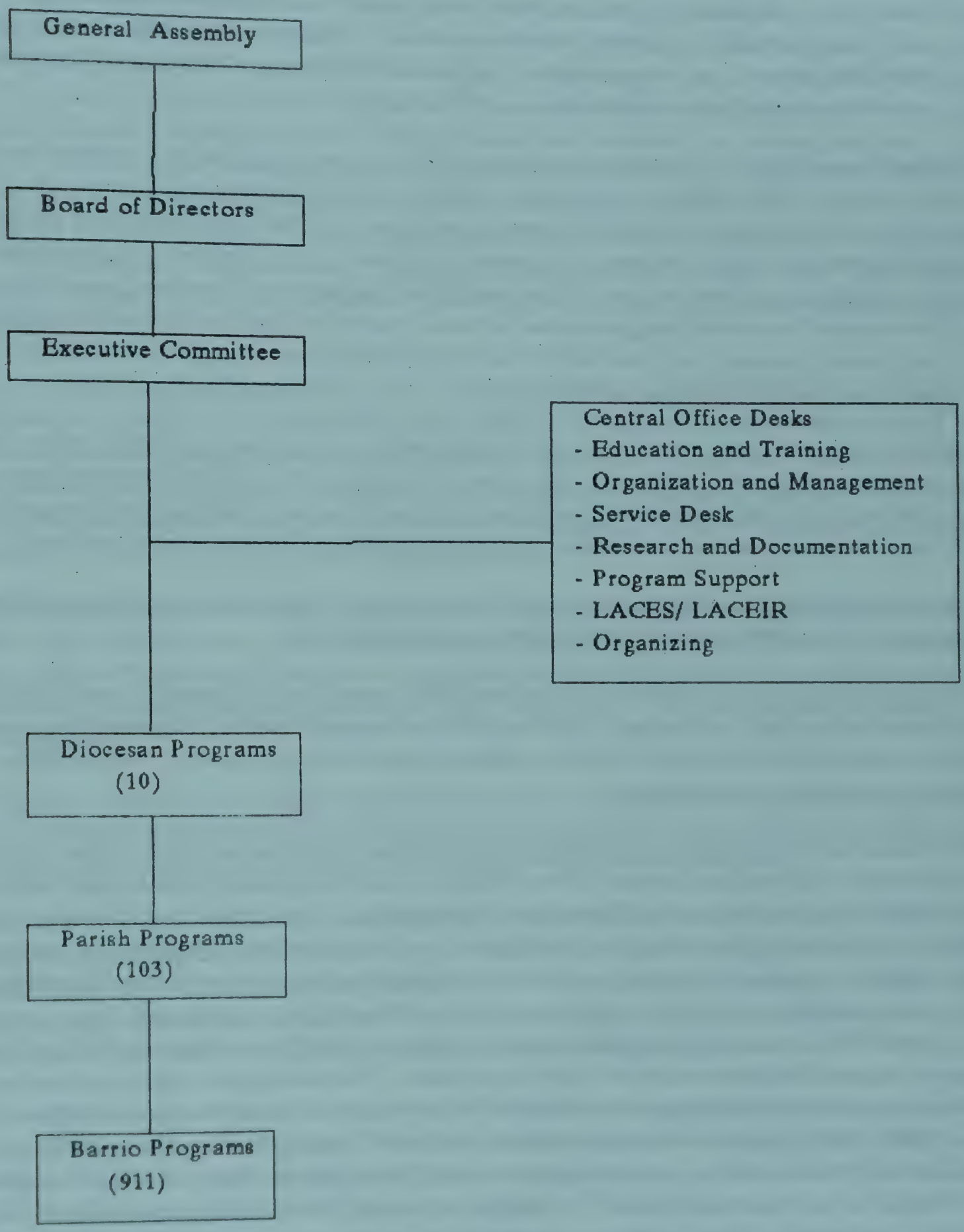


Chart 2: Organizational Chart of the CBHS, 1986-1990



The by-laws also stipulates that the Assembly be held on the last Saturday of the first month of the year at a venue within Davao City determined by the Board of Directors and with proper notice of the same. However, in practice, the Board, upon the recommendation of the Central Office staff, may determine a more convenient date. Only the Assembly can amend the Corporation's by laws and any change therein requires its ratification. The Assembly also elects the representatives to the corporation's Board of Directors.

Documents examined by the investigator show conflicting provisions on the composition of the Board of Directors. According to the by laws, CBHS's Board of Directors is composed of seven members, four of whom are provincial/diocesan coordinators and two representatives chosen from among the community health workers. The seventh member, is the President of the corporation, who is also the Program Coordinator. To be elected to the Board of Directors, one must possess the additional qualification of being a member of the corporation. The Directors are elected during the annual general assembly and hold office for a term of one year until their successors are duly elected and shall have been duly qualified.

Another document states that the Board is composed of fifteen members one of whom shall be a representative of the Rural Missionaries of the Philippines. One of the members should be a lawyer. Representatives of the staff, the community health workers, and sectoral groups such as health, labor, women, peasant and church organizations complete the fifteen-person Board.

The current Board, however, is composed of seven members, four of whom are Diocesan Program Coordinators, two CHWs, and the President/Program Coordinator.

It is by the Board that the power of the corporation is exercised, its property controlled, and its business and other affairs conducted. The Board holds an annual meeting, has overall responsibility over the supervision of funds and project implementation, and ensures that the decisions of the Assembly are properly implemented.

The Executive Committee is responsible for overseeing the implementation of the program. It is responsible to the Program, accountable to the Board, and is supposed to meet every two months. Again, documents conflict on the Committee's composition. One states that it consists of three members of the Board, including the Coordinator, and two members appointed by the Board at large. Another document, however, says that the Committee is composed of the Coordinator and two other members selected from among the Board, or a total of three members. The Central Office headed by the Coordinator is referred to as "the service arm" of the Board. It oversees program implementation on a day-to-day basis. The development and coordination of the various components of the program are handled by the various desks of the Central Office. For the period 1983- 1985, these desks consisted of Education and Training, Services, Program Support, and Research and Documentation, and Organization and Management. As a result of the 1986 Staff Conference, a new desk was added, Linkages, Alliance, Coordination, and Student Exposure (LACES). In 1988, LACES' function was further expanded to include International Relations, and the desk is now known as LACEIR. The 1988 Staff Conference also recommended the addition of an Organizing Desk, for reasons cited earlier. However, this has not been formally constituted due to lack of funds and personnel.

Staffing

The day-to-day administration of the program rests on a management staff of six persons consisting of a Coordinator, Co- coordinator, Cashier-secretary, and two persons in General Services. The Coordinator (who is also legally the President of the Corporation but is more commonly referred to as Program Coordinator) heads the Central Office and assumes overall responsibility for program administration and implementation. She coordinates and monitors the various program desks, the program areas, and the personnel both at the Central Office and the program areas. She is tasked with ensuring program continuity and the sound management of funds and other resources. She represents the corporation to funding agencies and international, national, and local government and non-government organizations. Finally, she convenes the Program Area Coordinators, the Executive Committee, and the regional office staff for meetings and holds activities that promote staff development.

In the absence of the Coordinator, these responsibilities are assumed by the Co-coordinator, and to lighten the load of the Coordinator, she also has been given primary responsibility for the monitoring of local programs and the analysis and preparation of reports to funding agencies, and the consolidation of the quarterly reports submitted by local programs. Finally, since the positions in the Program Support Desk are currently unfilled owing to lack of funds and personnel, the functions of that desk have also been delegated to her.

Of the staff members assigned to general services, one is tasked with providing technical assistance to the program and other staff members. He is responsible for what is referred to as "reprographical" jobs which include the reproduction of training handouts and other materials for publication, collating these and other reports and forms, and cutting stencils and maintaining these for future use.

The other staff member in general services assists the Central Office in purchasing, bank transactions, and communications. He is in charge of maintaining office orderliness and cleanliness and, during periods of heavy clerical work, does typing jobs for the various desks.

The administrative officer is concurrently the bookkeeper and finance officer. As administrative officer, his responsibilities include the filing of records and the recording of incoming and outgoing communications. He acts as the comptroller of office supplies and acknowledges receipt of reports from the program areas and communications from funding agencies. Lastly, he also assists in typing reports and other documents and in preparing the operational budget.

The other seven personnel in the Central Office service the various desks: two are in Training, four in RDIC, and one in services. Three staff members, however, are currently on leave, forcing the others to assume multiple positions. Thus, as mentioned earlier, the Co-coordinator has also been given the responsibilities over the Program Support Desk, while the functions of the Education and Training and Services and Activities Desks are being handled by only one person. The work of the LACEIR desk, on the other hand, has been distributed among the Coordinator, Co-coordinator, and the Services and Activities Desk Coordinator who, therefore, has responsibilities in three desks.

Of the thirteen staff members of the Central Office (including those who are currently on leave), four have been with CBHS for less than one year, while another four have been with the organization for less than two years. Only two have been with the program for over five years. Moreover, one of the personnel in the Research, Documentation, Information and Communications Desk is a foreign volunteer whose tenure with the organization will end in 1990. The current Program Coordinator's term also ends in 1990, making the average tenure of Program Coordinators since 1983 less than two years. (The implications of this very high rate of staff turn-over will be discussed in the concluding section.)

Decision-Making

Decision-making in all matters - from program implementation to management - follows participatory lines. This is achieved through a series of consultations, meetings, and conferences starting from the CHWs themselves and the parish level staff to the Board of Directors and to the Assembly where all units are duly represented.

Mention has already been made of the composition of the Assembly, the Board of Directors, and the Executive Committee. In the the day-to-day administration of the program lodged with the Central Office, participatory decision-making is done through the Management Committee composed of the Coordinator, Co- coordinator, the finance officer and the head of all the service desks. Meeting weekly, the management committee is the forum for discussing the progress of program implementation and problems related to these.

A staff meeting of the personnel of the Central Office is held monthly and when the need arises. Matters discussed at these meetings concern administrative issues.

The Program Coordinators Meeting, on the other hand, brings together the heads of the various desks in the Central Office, the Coordinator, the Co-coordinator, and the eleven diocesan/provincial Program Coordinators. The Coordinators Meeting is a forum where each of the eleven Program Coordinators present a report on the progress of program implementation in their respective areas and for finding solutions to common problems. In previous years, the Coordinators Meeting was held quarterly. They found, however, that this kept them away from their areas too often (the meetings are convened in Davao) and too long (the meeting lasts for three days). Thus, they themselves decided to experiment with a bi-annual meeting in 1989, an experiment which will be assessed in their next meeting in January 1990.

Finally, a Staff Conference is convened every two years. The participants to the Conference are the same as those of the General Assembly. The difference between the two meetings lie in the matters that are taken-up. The meeting is referred to as the Assembly or General Assembly when the matters to be discussed are organizational issues, such as amendments to the by laws and constitution and revisions of the organizational structure. It is referred to as the Staff Conference when the agenda concerns matters relating to program implementation. In the most recent Staff Conference, for example, the program of program implementation was assessed, the strengths and

weaknesses of the various components identified, and the thrusts and orientation for the next two-year period were defined.

Monitoring and Evaluation

The Central Office monitors local program implementation primarily through the progress reports submitted by the diocesan/provincial programs. In previous years, quarterly reports were required. For 1989, however, the diocesan/provincial coordinators suggested and the regional office concurred to experiment with bi-annual reporting since the preparation of quarterly reports took too much time that tied the program staff members to offices for lengthy periods. Like the annual coordinator's meeting, at which these reports are presented and discussed, the bi-annual reporting system will be evaluated in the next coordinators meeting in January 1990.

Except for the annual visit of the Finance Officer to audit the books of the diocesan/provincial programs, area visits for monitoring program implementation are not made regularly, owing reportedly to lack of personnel. Central Office staff members, however, who happen to be in the program areas for other missions (e.g. acting as resource persons in training activities) almost always use the opportunity to inquire into developments in these areas.

The Desks of CBHS

The various desks of the CBHS Central Office are the major channels of service provision to the Diocesan/Provincial Programs. These are Education and Training; Services and Activity; Research, Documentation, Information and Communication (RDIC); Linkages, Alliances, Coordination, Exposure and International Relations (LACEIR); Program Support; and Community Organizing. In this section, the functions and activities of these desks are described. The focus is on current thrusts, although where information is available and relevant, these are compared with previous orientations.

Education and Training

The two main functions of the Education and Training Desk are 1) to assist local programs review and upgrade their training designs, methodologies and training materials and 2) to promote and build popular awareness of the community-based health concept and orientation. Functions related to these include monitoring the training activities of the local programs, providing assistance in developing trainors and identifying training needs, and conducting health and non-health skills and in-service training.

Currently, Education and Training's efforts concentrate on

1) the provision of essential technology and expertise to organized communities, through the Diocesan/Provincial and Parish/Municipal Programs, to facilitate the establishment of health committees/staff of existing people's organizations and

2) assistance in the consolidation of basic and advanced health skills and knowledge.

Because of the high rate of personnel in the Central Office, the Diocesan/Provincial and Parish/Municipal programs, and among the CHWs themselves, it was also found necessary to work on

3) deepening the knowledge and understanding of all the guiding principles of the community -based health approach and

4) the development of trainors.

Through the years, E and T Desk has continuously attempted to refine its training courses. Drawing on the experiences of other NGOs and its own assessment of the contents of previous curricula, the training modules currently in use are broader in content and scope than those used during the early years of the community-based health program. The Basic Health Skills curriculum covers thirteen topics, including Orientation (to the National and Health Situation, Concepts of Health and Disease, Environmental Sanitation, History Taking, Anatomy and Physiology, Signs and Symptoms of Common Diseases, Basic Nursing Care and Techniques, Nutrition, Maternal and Child Care, First Aid, Oriental Medicine, Simple Pharmacology, and Preventive Dentistry. Local programs are encouraged to revise this curriculum (and which they often do) to more adequately meet the needs of the situation in their areas and/or those of a particular audience.

In recent years, the E and T Desk has also developed training modules in advanced topics including Oriental Medicine (Acupuncture I and II), Nursing Techniques, Microscopy, Simple Pharmacology, Basic Dentistry and Advanced First Aid. In addition to these health courses, the Desk is also developing a standardized, but flexible, curricula for such non-health topics as Community Organizing, Teaching and Learning Skills, and Program Management in accordance with the needs identified during the assessment conducted in 1988.

Other notable activities of the E and T Desk in the last three years include the launching of the Mindanao-wide Consultation in June 1987 which reviewed the community-based health program philosophy and the tasks of the personnel of the desk, trainors, and CHWs. Following this consultation, a workshop on the program's philosophy was held in September of the same year, resulting in the preparation of a module and visual aids on it. Other materials prepared at this time were a module on Teaching-Learning Skills and a handout on Chinese Massage and Therapeutics which is used for advanced training in Oriental Medicine. The former was subsequently pretested in three program areas , revised, and has since been used in upgrading the skills of trainors. A skills and knowledge evaluation of CHWs was also launched in May 1987, was pretested in one program area, revised, and is being used in assessing the capabilities of the CHWs.

In 1988, training on three advanced topics were launched, namely, Differential Diagnosis, Pharmacotherapeutics, and Under Five Clinic (UFC). Differential diagnosis aimed to eventually raise the level of skills of CHWs "from symptomatic to diagnostic." A module on differential diagnosis was subsequently prepared, pretested, and is now being finalized. The training on Pharmacotherapeutics was also aimed at equipping CHWs with specialized skills to meet the growing demands of their clientele. The training course includes such topics as Pharmacodynamics and Pharmacokinetics as well as rational drug use and the management of *Botika sa Barangay*.

In their own assessment of the E and T desk for the period 1986-88, participants to 1988 Staff Conference concluded that its training activities resulted in program promotion and expansion and a deepening of the commitment of CHWs. Moreover, these activities promoted the health and the health awareness of the people in the communities. The activities for 1988 included 652 community orientation sessions, 342 Basic Health Skills Trainings, and 47 trainings in advanced health topics. For non- health trainings, 93 were conducted on both management techniques and the development of teaching-learning skills. Finally, nine trainors trainings were held while staff skills were upgraded through 86 in-service training sessions.

Services and Activities

Program documents list the following as the functions of the Services and Activities Desk:

1) to assist and consolidate all the CBHP components of the program areas with emphasis on preventive/primary health care;

2) to promote the development of the referral system including the referral network, skills, and processes;

3) to monitor and assess service activities in the program areas;

4) to assist in providing logistical/technical and material support (instruments, medicines, etc.) to the program areas;

5) to coordinate with GOs and NGOs in providing service during epidemics, emergencies and disasters; and

6) to initiate the formation of medical emergency teams in cases of socially induced and natural disasters.

In 1988, recognizing that the program areas were in different stages of development, the Desk adopted a strategy that would respond to their needs more adequately. Program areas were classified as either "expansion areas" or "organized communities." In the expansion areas, the thrust would be the provision of basic health services, while in the organized communities the emphasis would be placed on the provision of more comprehensive health services. In both, however, stress would still be placed on the improvement of the referral process. Further, due to developments in many program areas, efforts would be exerted to equip the staff of the local programs with skills in

responding to disaster situations such as massive evacuation. Lastly, as it was found that service in previous years focused on curative medicine, efforts would also be exerted to launch more preventive health activities such as immunization and sanitation drives. Indeed, for the period between July and December 1988, some 75,000 patients were reported to have been individually cared for and/or treated by CHWs, following the system of recording suggested by the Central Office. The programs as well as the Central Office also reported 805 patients referred for secondary care as their conditions were beyond the capacity of the local programs. Moreover, in addition to the regular clinics held in the program offices on scheduled days, the eleven programs conducted 287 "organized clinics" attending to around 5,559 patients. Two hundred seventeen (217) of these clinics were "medical, 27 were "dental," 35 "surgical" while 8 were "immunizations." Eighteen (18) laboratory services consisting of blood smear for malarial parasites, fecalysis, urinalysis, blood typing, hemoglobin count and sputum microscopy were conducted with some 1,063 specimens examined. There were, however, no figures reported on the number of health education classes conducted nor of sanitation campaigns held, the vehicles by which preventive medicine is promoted.

Since its inception in 1975, the earlier CBHP organization had developed linkages and alliances and coordinated with GOs and local and international NGOs, hosted local and foreign visitors for brief stays in program areas, and had exposed students in medical and related fields to CBHP through its summer program. However, LACES did not become a desk of CBHS until 1986, and thereby recognizing the importance of such relationships and activities for gaining moral, technical, and financial support for the program. The early efforts of the desk were focused on simply increasing the number of contacts CBHS had with individuals, groups and organizations who could be supportive of the program and in coordinating with individuals, agencies and programs working toward the same goals as CBHS. Thus, soon after CBHS became independent of MISSSA in 1983, closer linkages with local, national and international health organizations were established. A coordinating relationship was forged with the Diocese of Basilan and with national agencies such as AKAP, the Asian Community Health Action Network, and others mentioned earlier. The 1986 Staff Assessment of this component, however, showed there was a general lack of understanding of the orientation and importance of LACES work, and was thus not given proper attention. The assessment done in 1988 drew similar conclusions. It was still generally agreed that there was no unified understanding of the approaches to LACES work and the processes necessary to implement its mandate. Indeed, a reading of the progress reports of both H an D and CBHS between 1983 and 1988 showed a gradual decrease in LACES-related activities. For example, while forty-nine medical, dental, and nursing students participated in student exposure program in 1982 and 1983, only seventeen joined in 1984 (of whom twelve did not complete the program) fourteen in 1985 and nine in 1986. By 1987, no further mention of the student exposure program was made. HEAL-Mindanao, the organization health professionals and paramedical workers established with much flourish in 1983, became largely inactive in 1986. It became active again in 1987 when its own Secretariat was set-up to improve and facilitate activities.

CBHS, however, continued hosting local and foreign visitors for very brief stays in program areas. And a breakthrough of sorts in its relationship with government occurred in 1986 when the Minister of Health of the newly-installed Aquino administration invited CBHS to participate in the government's new program (known as the Rural Health Practice Program or RHPP) of sending new medical graduates to work in the rural areas for six months. But no volunteers worked in CBHS areas after the batch of six in 1986.

In view of the findings of both the 1986 and 1988 assessments, the participants to the 1988 conference drew up a plan of action for LACES (and voted to add International Relations to its functions, thereby changing the Desk's title to LACEIR). Identified as the basic thrust of the Desk is the promotion of community-based health programs by propagating earlier program experience in Mindanao to gain more financial and technical support for the genuine development of communities to solve their own health care needs. Relations with programs, agencies, and individuals working in health or promoting the people's welfare were to be forged. With these, CBHS' relationship can be either of three. It can have a 1) "linkage," where the relationship is loose, with whom it has no binding commitments; 2) a "coordination," where the relationship is made on a project-to-project basis and, therefore, a very specific and short-term agreement; or 3) a "network," where the agency or group concerned shares with CBHS a common orientation and set of objectives and can therefore be the basis for deeper ties.

The exposure program was seen as an important way to interest people in the community-based health program and to raise their level of awareness on the health situation in the rural areas. On the other hand, international relations work aimed to deepen the international understanding particularly of those involved in health of the international roots of oppression and thus of poverty and the ill-health of the Filipinos and other peoples. Conversely, through international solidarity work, CBHS hoped to gain understanding of the health problems faced by other peoples and learn from their attempts to solve these. A concept paper was to have been prepared to guide the operation of the student exposure program. However, this has not been accomplished and international relations work continues to be minimally attended to and has still not become a priority concern.

Research, Documentation, and Information and Communication (RDIC)

Interviews with CBHS personnel revealed that in previous years the program areas did not fully appreciate the need for the RDIC desk because its role in the program was not clearly understood. To begin with, this component developed as a response primarily to the needs of the Central Office for data in the preparation of reports to funding agencies, and not of the program areas whose priorities were focused on the services of the Education and Training, Organization and Management, Services and Activities, and to a lesser extent, the LACEIR desks. As an indication of this, RDIC was not discussed during the 1986 Staff Conference. It was eventually assessed in the 1988 Conference where its role in the community-based health program was defined and its thrusts identified.

Indeed, progress reports between 1983 and 1988 contained very few entries for the RDIC desk. The report for the period July to December 1985 noted the importance of research skills trainings

specifically on reporting system, data banking, and health statistics and in 1987 a member of the Central Office staff was reported to have attended a National Participatory Research Consultation. In the same year, the Desk conducted trainings on record keeping and filing for the staff of the Central Office staff and some local programs areas and another on health statistics for Program Coordinators. It also assisted the Organization and Management Desk by producing the quarterly reporting form and individual report form for the latter's use and the instruments used in the assessment of the skills and knowledge of CHWs. In 1986 it prepared the 1986 Mindanao Health Profile, providing data and information on the health work in Mindanao. Finally, it worked on the systematization of library operations, a data bank and on formulating policies and procedures relating to the use of the library and other materials.

In order, therefore, to strengthen the RDIC desk, the 1988 Staff Conference defined its major function which is to facilitate the development of health programs through relevant program implementation. It was to continue assisting the program staff to facilitate efficient and more systematic program management and monitoring through the upgrading of the recording, filing, and reporting systems. It would also continue to assist the program to facilitate efficient and more systematic program management and monitoring through the implementation of a program-wide community diagnosis survey. In partial fulfillment of this mandate, the Desk has recently completed the community diagnosis questionnaire and the actual survey is currently underway in several barangays.

The other major activity of the RDIC Desk is the publication of the bi-monthly newsletter of the Central Office, *Paambit Panglawas* or PP. PP was originally a project of H and D and became the responsibility of CBHS when H and D merged with CBHS in 1987.

It is claimed that PP is the only health newsletter that is reaching the grassroots. The content of the newsletter varies, ranging from health updates and feature stories to program activities and reprints of articles published in Health Alert Drug Monitor (HAIN) and national and local dailies. The publication is reportedly being used by CHWs as a reference material for their health and mass education campaigns and is found useful since it is in Cebuano which can be easily understood by the CHWs and the people. In 1988, two issues of PP were produced, with a run of 700 copies. Also used by CHWs in their mass education campaigns are the primers produced by the RDIC. The most recent of these is the Cebuano primer on Pesticides containing information on the hazardous effects of pesticides on health and the environment. Again, this was found to be particularly useful due to the prevalence of pesticide use in the rural areas.

Organization and Management

The demand for the services of the Organization and Management Desk has always been acute owing to the generally high turnover of program staff at all levels and the need to train personnel, particularly those coming from health related fields, in management and other skills. Even those with previously acquired skills have to be retrained since it is felt that the skills needed to manage a community-based health program are different from those for other agencies. In view of these, the major functions of the Organization and Management Desk were identified to be

1) to develop health workers at the parish level to carry out a management role within the parish program;

2) to undertake staff development at all levels in program organization and management;

3) to continuously improve the monitoring system at all levels within the programs;

4) to carry-out regular assessment and planning sessions at the diocesan levels;

5) to continuously upgrade the assessment and planning system; and

6) to promote community participation in planning and monitoring activities.

In the 1986 assessment of the Organization and Management component, it was generally agreed that there was a lack of knowledge and skills in managing the program at all levels. Secondly, the role and functions of the local programs were unclear which resulted in overlapping tasks and activities. Following this assessment, the conference participants proceeded to define the roles and functions of the diocesan/provincial coordinator, the parish coordinators, the diocesan staff, and the parish trainors. It also identified the thrust of the component for the coming years which is to raise the capacity of the program staff and systematize all aspects of program management and implementation at all levels. However, it is not clear from the reports what activities were undertaken between 1986 and 1988 to upgrade the managerial skills of the program staff. Except for a seven-day Mindanao-wide Finance Management Training in January 1988, no other management seminars or workshops were reported for the period. It is therefore not surprising that in 1988 the same assessment of the Organization and Management Desk was noted, that is, the main problem was still the deficiency in management skills of the program staff.

Community Organizing

One of the major points that surfaced during the 1988 Staff Conference was that people's empowerment through people's participation, which was the guiding principle of the community- based health program, was being realized in organized areas through sectoral and people's organizations. In unorganized areas, however, it was revealed that community-based health programs had not sufficiently contributed to the development of people's participation. In these communities, decision-making became the prerogative of the program staff.

Participants to the conference also agreed that the same strategies used in both organized and unorganized communities, and efforts were focused on the health component, neglecting the program's community-based or organizing component. At the same time, it was shown that previously organized communities were becoming "unorganized" owing to increasing military operations, the liquidation of the leaders of people's organizations (causing the organizations to disband), and massive evacuation of whole communities.

In view of these developments, the Conference's participants agreed to set-up a Community Organizing desk at the Central Office. The Desk's main function was to assist people's efforts to establish and strengthen community organizations. It was envisioned that these organizations would facilitate the formation of health committees and, therefore, the delivery of better health services for the people which would, in turn, serve as a means to achieve the program's ultimate goal of helping build the foundations of a relevant health care system.

The functions of the Desk would involve the three activities community building, CHW organizing, and health sector organizing. Community building was seen "to facilitate community action to respond to its identity and its own health needs such as dialogues with government health officials to avail of essential health services frpm government." Consultation with community leaders would be regularly conducted to be abl eto effectively coordinate program activities. To accurately determine the concrete situation in the communities, a community diagnosis survey would be periodically conducted which would include the identification of community problems and needs which would be used as basis for responding to them.

CHW organizing, on the other hand, was aimed to ensure implementation of genuine people's participation in health care. CHW organizations would serve as a forum for sharing experiences, problems and other issues; as a means to unite on orientation, direction, and role in the program and community; as a body that would project community health issues and lead the mobilization of the community on these issues and promote and project community-based health programs locally, nationally, and internationally. Finally, health organizing was aimed to increase contacts with health professionals in order to harness their expertise for the needs of the community primarily through referrals and assist in upgrading the health skills of CHWs.

To attain these objectives, a three-stage implementation plan was prepared. During the first year, stress was to be placed on health organizing or assistance in facilitating the establishment of people's organizations in unorganized or "recovery" areas and the continued provision of training and health services in organized areas. In Phase II, the focus would be on skills consolidation and specialization and, anticipating that the progress of Phase I would be uneven, on the consolidation of the health committees in consonance with the pace of consolidation of the communities. In Phase II, it was envisioned that the role of the Program would already be primarily the provision of intermediate health services although it was recognized that health organizing and the consolidation of health committees would be a continuing process.

Although full implementation of the plans of the Organizing Desk awaits financial support from funding agencies, activities aimed to meet its objectives were reported to be already underway in many program areas. (See discussion on Program Implementation at the Local Level, below.)

The Management of Financial Resources, Funding, and Material Support for CBHP

Allocation of Resources

CBHS's system for allocating resources, like all other aspects of its operations, proceeds following participatory models. The first stage in the process is the submission by the eleven diocesan/provincial programs of a work and financial plan which details their projected activities and the financial requirements for these. Plans are usually prepared for a three- year period (chosen because most funding agencies provide assistance for three-year periods).

The diocesan/provincial work and financial plan is based on the needs and priorities of the parish/municipal programs while that of the Central Office includes the financial requirements of the proposed activities of the different Desks, the administrative staff, and the operations and maintenance of the office itself. Each of the Coordinators and, in the case of office maintenance and operations, the Administrative Officer prepare a plan for each of their units and these, along with those from the dioceses/provinces, are collated by the Finance Officer. The work and financial plan is then presented during the Program Coordinators meeting for review. After ensuring that the proposed activities fall within the approved thrusts and orientation for the period and if the projected expenses are found to be reasonable, the plan is forwarded to the Executive Committee which recommends it to the Board of Directors for approval. The Board may approve the plan as recommended or return it the Executive Committee should its members feel that adjustments need to be made. The approved budget is ratified by the Assembly and incorporated in the project proposal to be submitted to funding agencies.

Disbursements and Fund Releases

Once the Central Office receives notification of approval of the project proposal from funding agencies, the local programs are informed of the same. Should the amounts approved are those as requested in the project proposal, the local programs are advised to prepare an annual budget. On the other hand, if the grant approved is less than the requested financial support, the Program Coordinators and a representative of the Central Office are called to conference where the proposed activities are reprioritized to conform to the available resources. Funds to be allocated to the diocesan programs are released quarterly. The Coordinators of the desks and the administrative officer at the Central Office also prepare a yearly budget. However, funds are released to them when they are actually needed. Small expenses are drawn from a petty cash fund of P1,000.00 maintained by the cashier. For expenditures of less tha P100, only the approval of the cashier is needed. Those over P100, however, requires the approval of the Regional Coordinator. Large expenditures (more than P100.00) requires the preparation of a voucher approved by the Coordinator and Co-coordinator who are also the signatories to the organization's account with a local bank.

Monitoring of Financial Transactions

The Central Office requires a monthly financial report from its diocesan/provincial programs. This report summarizes program activities for the month, the budget originally proposed for each of these activities, and the actual expenses incurred for each. Supporting documents are not forwarded to the Central Office but are kept in the local office for examination by its finance officer who visits the diocesan/provincial offices to conduct an audit at least once a year.

External audit of the organization is conducted by-annualy to conform to the reporting requirements of funding agencies. For this, CBHS has retained the services of an independent certified public accountant.

Finances

Through its almost nine years of existence, CBHS has kept a fairly regular and organized record of its finances. Audited financial statements prepared bi-annually by the organization's external auditor are available for all these years. It also has on its files the financial statements of Health and Development- Mindanao from 1981 to 1987. Although H and D was organizationally and financially independent of CBHS, when it was dissolved in 1987, CBHS assumed responsibility over its activities and inherited its finances.

Limiting the discussion first to the financial condition of CBHS, documents and interviews show the funds CBHS uses to finance its activities and maintain operations come largely from the grants provided it by Misereor, the development arm of the Bishops Conference of Germany. The audited financial statements reveal that between January 1981 and October 1988 CBHS received a cash grant (referred to in the statements as "subsidy") from Misereor totaling P8,542,637.76, accounting for almost 84 percent of the total cash grants received by CBHS from (foreign) funding agencies, and almost 80 percent of all cash receipts. (Please refer to Table 1 which presents a consolidated financial statement of CBHS between 1988 and July 1989.) In 1988, CBHS also became the recipient of smaller grants from other foreign agencies such as Christian Aid, Trocaire, Swiss Lenten, and Oxfam. The funds received from these agencies between January 1988 and July 1989 totaled P1,656,816.68, representing a little over 16 percent of total receipts from funding agencies and less than 16 percent of cash receipts from all sources. Donations and contributions from local sources which totaled P344,062.57 accounted for another 3.2 percent of CBHS' cash resources. Other income, including collected receivables, liquidation of advances, registration fees, and interest on deposits amounting to P173,829.73 accounted for less than two percent.

The statements also show that CBHS has provided local counterpart contributions with a cash equivalent of P2,391,253.29. These contributions in kind represent imputed expenditures for trainings, seminars, and conferences; travel and transportation; office supplies; and personnel expenses at the parish level.

Table 1: Consolidated Financial Statement of CBHS for the Period from January 1, 1983 to December 31, 1988

Income

Cash Grants		Percent of Grants
Misereor	PhP 8,542,637.76	83.7
Christian Aid	591,221.46	5.8
Trocaire	648,706.69	6.3
Swiss Lenten	222,047.53	2.2
Oxfam	194,841.00	2.0

Other Income		Percent of Total Income
Local Donations/ Contributions	344,062.57	3.2
Others/Registration	56,172.25	.05
Collected Receivables/ Liquidation of Advances	78,419.30	.07
Interest on Deposits	39,238.25	.03
Total	10,717,346.81	

Expenses

		Percent of Expenses
Salaries, Honoraria, Allowances/Personnel, Staff Benefits	4,685,993.52	41.5
Seminars and Training	3,160,357.59	28.0
Travel and Transportation	870,346.69	8.0
Consultations and Meetings/ Conferences	564,600.05	5.0
Miscellaneous	392,992.93	3.5
Accounts Receivable, Advances, Loans Paid	383,930.14	3.4
Stationary and Supplies	314,263.65	2.8

Expenses

		Percent of Expenses
Office Equipment	180,520.73	1.6
Training Materials/Basic Kits/Instruments	160,094.70	1.5
Books and Subscription	118,462.85	1.1
Staff Development	109,230.90	1.1
Office Maintenance	108,428.04	1.0
Literature and Duplication	106,648.92	1.0
Communications/Postage, Telephone, Telegraph	88,324.39	.08
Professional Fees	33,600.00	.03
Bank Charges	31,431.38	.03
Furniture and Fixtures	4,657.15	.01
TOTAL	11,313,883.63	
BALANCE/(DEFICIT)	(596,536.82)	
Add Beginning Deficit	40,706.88	
BALANCE/DEFICIT	(637,243.70)	

As expenditures for the same period totaled P11,313,883.46, CBHS, therefore, operated on a cash deficit of P596,536.82, and since it started the period with a deficit of P/40,706.88, its net cash deficit from January 1983 to December 1988 amounted to P637,243.70. This was partly covered by loans from other NGOs, amounting to P1,449,278.69. It must be emphasized, however, that when these loans were incurred, they were intended as bridge funds to tide the organization over during the period while waiting for the (delayed) remittances from funding agencies. But after funding agencies had remitted all their commitments to CBHS, however, the loans' effect on the organization's finances was still a net cash deficit in the amount of P2,086,522.39. When the deficit of P8,045.29 that CBHS inherited from of H and D when the two organizations merged in 1987, CBHS total deficit as of December 31, 1988 was P2,094,567.68. (See Table for H and D's consolidated financial statement for the period December 1981 to December 1987.) Major expenditures went to personnel salaries and benefits, honoraria, and allowances where 44.7 percent of the total cash receipts for the six-year period went and which represented 41.5 percent of total expenses. While CBHS' expenditure for this item falls within acceptable levels ralative to other items, salaries of personnel fall below not only the prevailing market rates but also even of the legally mandated minimum. Midwives are paid only between P800 and P1,500 a month, while nurses between P1,700 and P1,950. There are, moreover, non-health personnel who receive as low a compensation as P400 a month. Of CBHS staff complement, only doctors receive what may be considered a "decent wage" of P5,000 a month, although is this still way below what they can earn outside the program. And, CBHS is able to pay its doctors this rate only because it received a grant from Oxfam specifically to upgrade doctors' salaries. The grant, however, will last only for three years, and there is no assurance that it will be renewed after that time. One of the consequences of these substandard salaries is the high rate of staff turnover, which has already been discussed earlier.

The other major expense of CBHS is the holding of seminars and training activities which account for 28 percent of total expenses and use 30 percent of cash receipts. Another eight percent of the expenses went to travel and transportation and five percent to consultations, meetings, and conferences. The remaining expense items - stationary and supplies; office equipment; training materials, basic kits, and instruments; office maintenance; postage, telephone, and telegraph; and furniture and fixtures - accounted for 17.5 percent.

Community Support

Because grants from funding agencies are insufficient to fully cover operating costs, the success of the program depends on the community's support for it. However, although the concept of a community-based health program is premised on the beneficiaries' involvement in it, present realities are such that they cannot be expected to provide much material support, other than, for example, providing food for the participants in training activities and small monetary contributions for the transportation expense of CHWs. Program proponents therefore must rely on other sectors for this much-needed support and assistance.

Since CBHS has administered the program primarily through the Church, this support has come largely from the bishops and the priests. Although CBHS has encountered difficulties with a

Table 2. Consolidated Financial Statement of Health and Development - Mindanao for the Period December 1981 to December 1987.

Period	Total Receipts	Total Expenditures	Balance
Dec. 1981to Nov. 1983	PhP 1,785,849.09	PhP 1,729,650.63	PhP 59,198.46
Dec. 1983 to June 1984	412,619.26	545,379.94	(76,562.22)
July 1984 to Dec. 1984	463,442.75	612,341.11	(225,460.58)
Jan. 1985 to June 1985	736,895.44	595,263.82	(84,828.96)
July 1985 to Dec. 1985	862,540.70	561,056.12	(216,655.62)
Jan. 1986 to June 1986	1,195,533.43	631,138.61	781,050.44
July 1986 to March 1987		784,867.07	(3,816.63)
July 1987 to Dec. 1987	397,676.05	401,904.71	(8,045.29)

number of bishops (to be discussed below), the majority, some eight out of eleven bishops, at least "give the program in their dioceses moral support." The extent of the support of the bishops in CBHS' network, like those in the RM areas, depends on the individual clergy's perception of the importance of the program and the resources at his disposal. An excellent example of a Bishop who has given the program "his fullest support" is the Bishop of the Diocese of Kidapawan. While all Bishops provide office space for the program staff and some, additional space for a small clinic, the Diocese of Kidapawan, in addition to these, grants the program financial support to pay the Parish Coordinators an honorarium of P500 each a month. The Diocese also actively solicits material support from its own network for the use of the program, which has included medicines, office equipment, and other supplies. Finally, the diocesan seminar facilities are made available for the program's use at heavily discounted rates.

Parish priests also differ in their involvement in the health program. Although there are those who wish to give it their full support, resources at their command prevent them from giving nothing more than "moral support," but who are available to program staff and beneficiaries for (other kinds of) assistance. Others provide some office space or make available the parish convent or the parish hall for the health program's gatherings; donate, where available, a portion of the parish land for a communal herbal garden, allow use of parish facilities and equipment; contribute parish funds for the transportation of program staff members and CHWs and/or endorse solicitation letters to raise money for this.

In addition to the support from the clergy, the program has, in a few communities, also been able to generate support from officials of local government units. In the parish of Tulunan in Cotabato, for example, a member of the municipal council is actively involved in the health and other programs of the parish. As he owns a motorcycle, he acts as a liaison between the diocesan and parish staff and otherwise makes himself available for errands. He also participates in mass mobilization campaigns and, finally, assists CHWs who may encounter difficulties with the military and with which, he himself has had problems.

Other than these, the program also actively solicits the support of other government agencies and NGOs, professionals, and sectoral groups. The nature and extent of the support these groups have given are discussed elsewhere in the report.

Community-based Health Programs at the Local Level

This section of the report describes the administration and implementation of the community-based health program at the local - diocesan/provincial, parish/municipal, and barangay - levels. Like the preceding discussion on program management and implementation at the region- (Mindanao-) wide level, the following section details the various aspects of CBHS at these "lower" levels. The discussion is based primarily on the experience of the Diocese of Kidapawan (Province of Cotabato) where intensive interviews with the diocesan and parish staff members and a number of CHWs were conducted, visits to several parishes and barangays made, a number of program activities observed, and documents and reports read and analyzed. Information on other program

areas were also obtained through secondary sources, and these were incorporated into the discussion to compare the experience of Kidapawan with that of other program areas in an attempt to present the broadest spectrum of the program's coverage as possible.

Historical Development

Like most community-based health programs in the CBHS network, that of Kidapawan's was initiated at the request of the Bishop of the Diocese/Prelature who, at the time, was Monsignor Federico Escaler, S.J. The beginnings of the Kidapawan program are traced to the Third Prelature General Assembly held in 1980 (a meeting of the representatives of the fifteen parishes under the jurisdiction of the Diocese/Prelature of Kidapawan convened every two years). At this particular meeting (known as PGA III), the parish representatives submitted reports on the problems confronting their respective parishes. One of the most acute problems identified was that of health and it was generally agreed that the other programs would "move faster" if the health and health-related problems of the people, and those of church workers themselves, could be solved. Upon the strong recommendation of PGA III, therefore, Bishop Escaler sought the assistance of the MISSSA CBHP Board of Directors to set up a health program in the Diocese/Prelature of Kidapawan. The request was acted upon favorably. Before the Diocese could meet all the requirements, however, Bishop Escaler was transferred to the Diocese/Prelature of Ipil (also known as the Diocese/Prelature of Buug). It was already under the new Bishop, Orlando Quevedo, when the CBHP MISSSA Board of Directors approved funding for the program which was considered in place when the first batch of trainors had completed their training.

The first trainors training was conducted in November 1981, attended by fifteen participants representing fourteen (of the fifteen) parishes of the Prelature/Diocese. The participants were chosen by the Parish Teams (composed of the heads of the various parish programs). A volunteer nurse from Holland who was to head the Diocesan program also attended the training.

The training was conducted by a team headed by Dr. Jaime G. Tan and two other nurses. Lasting for ten consecutive days ("from early morning till late in the evening," recalls one informant), the training session included topics that form what is now referred to as the Basic Health Skills Training.

After completion of the course, the fifteen newly-trained trainors returned to their respective parishes and, in the words of the same informant, "full of enthusiasm, we immediately proceeded to organize core groups." The parish core groups (PCG) consisted of representatives of the Gagmay Kristohanong Katilingban (GKK) or Basic Christian Communities (BCCs). In the case of the parish of M'lang, for example, the core group consisted of seven participants, chosen by the family groups (ten to fifteen families) of the seven initial GKKs (or Kapilya, consisting of five to ten family groups). (A GKK or Kapilya, therefore, is composed of between fifty and a hundred families or households.)

The newly-trained seven parish trainors (as they were referred to at that time) returned to their respective GKKs to conduct a series of consultations with the members of their GKKs. The aim of

these consultations was to orient the GKK members on the community-based health program and to choose their community health workers, each of whom was expected to "serve" a family group.

The process of initiating parish and barangay CBHPs in the other parishes of the Prelature/Diocese proceeded along the same lines, although the speed varied considerably from parish to parish and from barangay to barangay. In the parish of Kabacan, however, the trainor was unable to train a core group because, she laments, "the people were not yet organized into GKKs." (To date, a community-based health program has not yet been organized in that parish, although the Diocesan Program Staff occasionally conducts mass education campaigns there.) In the parish of the Arakan Valley, on the other hand, peace and order problems prevented the trainor (Minda) from "functioning." She was able to conduct one CHW training with twelve participants, however, before "pulling out" of the area to become a member of the first diocesan program staff. The peace and order situation improved a few months later, and one of the CHWs trained by Minda, Elmer, eventually assumed the position of parish trainor in July 1982. The trainors in four other parishes were unable to form core groups. In two (Bulakanon and Colombio) the chosen trainors were already holding positions in other parish programs and could not attend to the demands of the health program. In another, Carmen, the trainor was "busy with her profession, pharmacy," while one died (the trainor for Kidapawan parish).

When the health program was established in Kidapawan, it was organizationally a component of the Lay Leadership Program (LLP), one of the nine formation and service programs of the Diocese/Prelature. The first set of staff members of the health component consisted of two persons: Minda, who was supposed to have been the parish trainor for the Arakan Valley, and the volunteer nurse from Holland, Marijka. It was deemed logical to attach the health component to the LLP since the latter was tasked with organizing the Diocese's GKKs which could then be the entry point for health services to be provided by the health component.

In February 1983, as part of the collaborative efforts between Health and Development-Mindanao and CBHP, Dr. Tan returned to Kidapawan to convene the first batch of trainors for a three-day assessment of the progress of their work since their training in November 1981 and to discuss common problems. Dr. Tan also conducted a two-day training session on some topics (injections, first aid) that now form part of the curriculum for the Advanced Health Training Course. With this training, the trainors were deemed equipped to offer more topics in the Advanced Health Skills course to the parish core group members and the latter, to the CHWs. Prior to this, they were only capable of handling topics in the Basic Health Skills Training module.

As of the end of 1983, some 187 CHWs were either undergoing training or had completed the Basic Health Skills course (72). Of these, 158 were active and only 29 had dropped -out. As of this time also, CBHP was being initiated or was already in place in some 146 barangays.

Because of this expansion, the Dutch volunteer nurse who headed the health component proposed that it be elevated to the status of a program in the diocesan organization. "And she saw to it that it was made so," one informant recounts, prior to her departure from Kidapawan in March 1984. Now a "full-pledged" CBHP program, three nurses were hired, one of whom became the first Program Coordinator. The parish trainor of M'lang, Inday, was also requested to join the staff, now composed therefore of five members.

The Program Coordinator, however, resigned after only six months because of low wages (P500.00 per month), since the salaries of the health personnel were adjusted to conform with those of other diocesan units. The other two nurses followed several months later for the same reason. Inday was subsequently made officer-in-charge of the program and has been Coordinator since that time.

More staff movements followed. A midwife who was hired in December 1984 left in April 1986 to work in Marbel, South Cotabato. Beth, a nurse, resigned in 1988 to take up employment in Jeddah. An Italian medical volunteer, Paula, was with the program from April 1986 until February 1987. (She will again be with the program for two years beginning January 1990.) Two medical students apprenticed with the program under the Ministry of Health's RIIPP, but only for six months from July to December 1986.

Despite the very high rate of staff turn-over, the growth of the CBHP in Kidapawan between 1983 and 195 was phenomenal, indicated by almost 700 CHWs who had been trained or were undergoing training during the period. Area coverage also increased. After the failure of the first batch of trainors to form parish core groups in Kidapawan, Colombio, and Bulakanon, a trainors training was conducted for two participants (perhaps to ensure that at least one would function in case "something happened to the other") from each of these three parishes, raising the number of parishes with CBHPs to twelve.

Compared with the program's first year (1982) when about the only training conducted for CHWs was the BHST, the period between 1983 and 1985 saw the launching of trainings in more advanced and special topics - Acupuncture, Microscopy, Injection, Minor Surgery, as well as non-health topics for staff development.

One of highlights of the period was the special project called the Barangay Walking Blood Bank, piloted in the parish of M'lang. The project was a direct response to the demand for blood due to the high incidence of hemorrhage during pregnancy and childbirth. After the program staff was trained in blood typing, a census of the community was conducted, residents were blood-typed and, with their consent, a list was prepared and posted in their GKK chapels. In case of a need for blood transfusion, then, a donor could be approached with little loss of precious time. "The Walking Blood Bank saved many lives," according to one beneficiary.

The experiment in M'lang was considered a success that it was also implemented in all the other parishes. Other services that were started during the period were the T.B. program, immunization, and individual patient care. It was moreover at this time when organizations were formed to respond to the needs of the CHWs and limited fund-raising campaigns were initiated. Finally, to be able to meet the increasing demands for its services, the CBHP began to systematize its operating procedures and to link-up with both government agencies and other NGOs to support and complement its efforts.

As of the end of 1985, of the 204 barangays within the jurisdiction of the Diocese/Prelature, 76 had CBHPs in place and out of the 413 GKKs organized by then, 167 had at least one trained CHW. Between 1985 and June 1989, the number of barangays with a health program almost doubled (to 127), with a corresponding increase in the number of GKKs served by at least one CHW, from 167 to 280.

This very rapid growth is partially attributed to the relatively stable peace and order situation in the areas following the installation of Corazon Aquino as President of the Philippines in 1986. The "democratic space" prevailing then afforded program staff members to freely initiate the health program in many communities. People, on the other hand, more readily participated as "there was less fear of harassment."

Two parishes that experienced very high rates of expansion were President Roxas and the Arakan Valley. This led to the division of their respective programs in 1987. Antipas became independent of President Roxas while the Arakan Valley was split into Doroluman and Greenfield. Moreover, in 1988, with a more "sympathetic and supportive" cleric as parish priest, the parish of Carmen started its health program, leaving only one parish, Kabacan, still without one.

Because of the high CHW drop-out rate, the large majority of Education and Training activities between 1986 and the present continues to be the conduct of training sessions in basic health skills. Refresher courses were, however, held for CHWs who had persisted with the program, "to ensure that they still remember what they learned." Also, a number of trainings in the advanced health skills module and other special topics such as comprehensive minor surgery were launched and health campaigns and mass education were intensified, including immunization and sanitation drives.

The major development of the period was in the area of linkages and alliances. Although CBHP exerted efforts to relate with both government agencies and other non-government agencies since it was established, it was not until the beginning of 1986 that more specific areas of collaboration were defined and joint activities held. (These will be discussed in more detail in a separate section below.) Thus, currently the CBHP in Kidapawan maintains active links with the Integrated Provincial Health Offices of the Provinces of Cotabato and Sultan Kudarat (one parish of the diocese is in the province of Sultan Kudarat), the provincial and two emergency hospitals of the province of Cotabato, and seven Rural Health Units of the same province. It has referral arrangements with these hospitals as well as with five privately-run medical clinics, while three non-government organizations collaborate with CBHP in the areas where they both operate. Internationally, two organizations in Holland and one each from Hongkong and Italy relate with CBHP and support it materially, while the local church-run radio station provides free air time for a weekly thirty-minute radio program.

Setting-up CBHPs

In Kidapawan, as is clear from the foregoing discussion, health programs at the local levels are set-up using the church organization - from the diocese to the parish and, finally, to the people through their GKKs. This is also the pattern in the other program areas, although two diocesan programs, Dipolog and Bukidnon, have since been dissociated from the diocesan organization and have become what is referred to as "provincial" programs whose staff report and are responsible directly to CBHS. There are other diocesan programs which may eventually become provincial programs unless certain aspects of CBHS' relationship with the Bishops of these dioceses are

clarified. The problems in this relationship are exemplified by those between the Program and the Bishops of Dipolog and Bukidnon.

CBHS informants report that in Bukidnon the problems began to surface in 1986 when the Diocese convened the Pastoral Assembly without the representatives of local health programs in attendance. At the meeting, part of which was devoted to an evaluation and assessment of all the formation and service programs of the diocese, criticisms were raised against the health program. It was accused as "a breeding ground of subversives," citing the case of a community health worker who was apprehended for illegal possession of firearms. Its staff was also criticized for inviting resource persons to speak in the areas without prior clearance from the parish priests. The Assembly's decision was to allow the program to proceed with its work. A more thorough investigation and evaluation of all the parish programs were, however, recommended. Informants who were then with health program report though that this evaluation "did not push through" and they resented that they "were not given the opportunity to defend themselves. "The CHW was no longer with the program when he was arrested," a program staff member claimed.

Confounding the already delicate situation was the transfer of the Program Coordinator, a nun, to another assignment. CBHS staff members report that the Bishop hired a replacement without the agreed-upon consultation with the other CBHP personnel in the diocese and the Central Office who took this to mean that the Bishop was no longer interested in supporting CBHS's health program. In 1988, therefore, CBHS dissociated the Bukidnon program from the diocese and organized it as a Provincial Program. Of the eight parish programs in the diocese, six chose to remain within CBHS's network. Two, on the other hand, decided to join the health program which the Bishop established.

During the "crisis" in Bukidnon, the vicar-general of the diocese was quoted as having said that the community-based health program was "eighty percent community organizing, twenty percent health." The implied meaning of his statement was not lost on the health program's and CBHS's staff, and when he was appointed Bishop of Dipolog, "he brought with him this perception of the CBHP."

Informants report that soon after his return to Dipolog from the meeting of the Catholic Bishops Conference in February 1989, the Bishop was also quoted as saying that "he would not take responsibility over CBHP." Although he acknowledged that the program was providing much-needed services to the people and encouraged the parish priests of the diocese to continue supporting it, the diocesan health program and CBHS personnel were of the opinion that if "he felt that the program was doing the people of the diocese a lot of good, the church hierarchy should support it all the way, which he seemed not willing to do." His statements were therefore taken to mean that he would not raise serious objections if the diocese were freed of responsibility over the program. After much exchange between the Bishop and the CBHS central office which "led nowhere," the latter eventually decided to dissociate the program from the diocesan organization. Although "no expressed notice of severance" has been issued, CBHS now considers Dipolog a provincial program and has obtained clearances from the provincial government and the military authorities in the area to operate as such. The staff, however, continues to occupy the office space provided by the diocese.

In comparing diocesan and provincial programs, staff members note several advantages to being independent of the church. First, the staff is freed of some of the burden of meeting bureaucratic requirements. For example, they have one set of meetings less to attend and one set of reports less to prepare. Second, since some civilian and military authorities perceive the church as "supportive of subversives," the program's personnel are less "harassed" operating as workers of an independent non- government agency. "Once they give you the clearance, you have less to fear," was how one informant put it.

The local health program in Kidapawan is "fortunate to have operated under three Bishops who fully support it." Once it was considered in place at the diocesan level, the church organization was also used to set it up at the parishes and in the barangay through the GKKs. Since the program was established at the request of the parishes themselves, programs were initiated simultaneously in all the parishes after the first batch of trainors completed their training. As was noted earlier, however, not all were successful nor did they proceed at the same pace.

As the health program was initially not "independent" but a component of the diocese's Lay Leadership Program, the first parish trainors were drawn from the staff of that program. All the CHWs were also selected from the church's grassroots organizations, the GKKs.

Although the GKKs provided a ready organization for the health services provided by CBHP, there are a number of disadvantages to using them as entry points of the health program. Foremost of these is that, although the health services offered by the program are in theory open to all and not only to GKK members or Catholics, it has been Kidapawan's experience that non-Catholics do not participate in the activities of the GKKs and, thus, of the health program. And even if CHWs themselves believe in "the neutrality of medicine," and are willing to offer their services to both Catholics and non-Catholics alike, they are often prevented from doing so by the members of the GKKs to which they belong. One CHW, for example, "was scolded for treating a member of the United Church of Christ." Because of this, attempts are being made to use other organizations to introduce the health program in the barangays. In Kidapawan, however, this has not been successful. In only two communities was the barangay council used as entry points for the program. This is also the pattern in all the dioceses and provinces in CBHS' network. For example, although the programs in Bukidnon and Dipolog are now independent of the diocese, at the "lower" levels, church organizations - e.g., the parish and the GKKs are still used in almost all cases.

Program Management

As mentioned earlier, since 1984 the CBHP in Kidapawan has been a regular program of the Diocese of Kidapawan, along with four so called formation programs (Christian Formation, Family Life, Youth and Lay Leadership) and four other service programs (Justice and Peace, Tribal Filipinos, Social Action, and Cooperatives). As a regular diocesan program, the health program is represented in the Diocesan Pastoral Team, the body which is tasked with overseeing the nine programs, and to which they are all accountable. All programs, for example, present proposed activities to the body for approval prior to implementation and are subjected to a yearly assessment.

The Diocesan Pastoral Team is headed by the Bishop through his representative, the Pastoral Coordinator.

Each of the nine programs has its own "internal" organizational structure. In the case of the health program, the highest policy- and decision-making body is referred to as the (CBHP) Diocesan Core Group (DCG). It has a membership of seventeen, consisting of the five members of the diocesan staff and a representative, usually the CBHP Parish Coordinator, from twelve of the fourteen parish programs. Two parish programs (Antipas and Carmen), "being newly established," are not yet represented in the DCG. They are, however, invited to attend its meetings and although they have no voting rights, they must comply with its decisions. The organization of the parish CBHP reflects that of the diocese. Thus, the Parish Coordinator represents the program in the Parish Team composed of representatives of the other parish programs. Like the Diocesan Pastoral Team, the Parish Pastoral Team has responsibility over the various programs and to it the programs are ultimately accountable.

The health program of the parishes, likewise, have their own governing boards, the CBHP parish core group (PCG), the highest policy- and decision-making body at this level. It is composed of representatives from each of the GKK districts with health programs. (There are seven GKKs per district.) Current membership in the different parish core groups range from six to eight.

The day-to-day affairs of the diocesan CBHP in Kidapawan is currently administered by an all woman staff of five, about the average staff of the diocesan and provincial programs. Inday is the program coordinator as well as bookkeeper and person in- charge of the LACEIR component. Minda handles the education and training component and also functions as the cashier. Wiwing, who has a degree in commerce, is the secretary and doubles-up as the petty cash clerk, while Phoebe oversees the activities of the CHW organization.

Kidapawan is one of the six diocesan/provincial programs that has a medical doctor on its staff. Dr. Maglana (Moon) handles the services and activities component of the program. By January 1990, another physician, Paula, the Italian volunteer who was with the program in 1986-87, will again be with Kidapawan for two years. She will be put in-charge of the education and training component, temporarily replacing Minda who will be on maternity leave. Paula will be with the CBHP only on a part-time basis as she is also tasked with setting-up a diocesan training center for cultural minorities. Inday and Minda have been with the program since its inception, being among the first batch of trainors in November 1981, although Inday first served as parish trainor of M'lang before joining the diocesan staff in 1984. Phoebe was also a trainor in New Rizal before joining the diocesan staff in 1986. Moon, the medical doctor, has had considerable experience with the Rural Missionaries in Lanao before coming to Kidapawan. Only Wiwing, who was hired in 1988, did not have CBHP experience before joining the diocesan staff. She had, however, to undergo orientation in CBHP principles and philosophy when she was hired, as all program personnel at all levels do when they join the program.

Following the recommendations of the 1986 Staff Conference, the Coordinator oversees the implementation of the program. She assists the Diocesan Core Group in drawing up the implementation scheme and in preparing the program and financial reports. She represents the diocesan

program in meetings with funding agencies and other institutions and convenes evaluation meetings and planning sessions.

Perhaps because the staffing patterns of the dioceses and provinces vary, the 1986 staff conference did not define the duties and responsibilities of every position in the diocesan staff. It only specified that every other member of the diocesan staff is expected to accomplish the tasks within his/her area.

Following this recommendation and the general guidelines prescribed by the conference, Kidapawan drew up job descriptions for every position in the organization. Thus, the bookkeeper has responsibility over inventory, requisitions, the preparation of budgets and the recording of financial transactions. The cashier, on the other hand, prepares vouchers, issues official receipts and disburses funds.

Of the service components, education and training is responsible for conducting trainings for the diocesan staff and the parish trainors and assists the latter in their training activities for CHWs. These include community orientation seminars; health classes; in-service, non-health, and staff development trainings. It also conducts outreach projects as well as monitors the various training curricula and revises them to suit the needs of particular areas and audiences.

The services and activities component is tasked with the provision of direct health services, including patient care follow-up, referrals, immunization and sanitation campaigns, and clinics. It is also responsible for evaluating the health skills of CHWs, coordinates with the education and training component and assists the latter in conducting health skills training for the parish staff and community health workers. In previous years, the primary concern of the organization and management component was the welfare of CHWs. It oversaw the CHW organization already formed in the diocese and parishes and encourages the formation of the same in other parishes through "core building" sessions. After the staff conference in 1988, organization and management has also been conducting orientation seminars and meetings in all the GKK districts, starting with those where "previous community organizing was weak."

Due to lack of personnel, the staff member assigned to organization and management has also responsibility over the activities of Research, Documentation, and Information Communication (RDIC). These are, however, limited to gathering data and information that are needed by the regional office.

The responsibility of overseeing the implementation of the program at the parish falls on the parish program coordinator. His specific tasks include providing guidance to the parish core group, monitoring the activities of the CHWs, gathering data and keeping records, attending diocesan meetings, representing the program in the parish team, and preparing reports and submitting these to the diocesan staff.

A body of from six to eight members, the parish core group assists the parish coordinator in his responsibilities. Members of the core group are outstanding CHWs deemed to have the potential "to deepen their health skills" and the aptitude to impart these to others. Thus, they are primarily tasked with implementing the education and training component at the parish level. In particular,

they monitor the skills of the CHWs in the parish, organize training activities and give lectures in these, and assist the CHWs in their health classes and community orientation seminars.

Monitoring and Evaluation

Monitoring and evaluation of program implementation at the local levels are, one informant enthused, "participatory." Monitoring and evaluation of CHW activities are based on the reports of the CHWs to the parish core group. These reports of the CHWs are then discussed during the quarterly meeting of the DCG, which lasts three full days, which the diocesan program coordinator or her representative attends if schedule permits.

Community health workers, however, do not consistently record their activities which is the major problem confronting the DCG in preparing the parish quarterly report. This often resulted in the under-reporting, for example, of the number of individuals cared or treated by CHWs for a particular period.

"Many CHWs can not seem to see the importance of recording things," complained one parish core group member. Some, in fact, do, but for various other reasons are unable to write reports. Many are simply not used to writing. Others find the exercise novel, but as one reasoned, "It's impossible to write when you are planting rice and somebody comes to you for treatment. One does not carry the forms and pencil to the (rice) fields." Thus, since CHWs "could not really be forced to record their activities consistently," a parish core group member said, "a solution that was adopted was to present both, in the case of "number of individuals served, actually recorded cases and estimates of these." The estimates are arrived at during the monthly district meetings of CHWs which at least one parish core group member attends. It is the latter, in fact, who writes the reports, basing them on the oral presentation of the CHWs.

The diocesan core group uses the parish quarterly reports in preparing the diocesan report submitted to the CBHS office in Davao. The diocesan core group meets for this activity also quarterly. The quarterly assessment takes three days as all parish coordinators first present an oral report prior to discussions of these by the body and the preparation of the final report. The assessment for the last quarter, however, extends for five days, two days of which are devoted to the assessment of program implementation for the year. Held in December, the last quarter and annual assessments end with a Christmas party which the families of the core group and the diocesan staff members attend.

The Community Health Workers

As stated in the case study of the RM CBHDP, the community health workers, or CHWs, provide the crucial link between the parish program personnel and the people. In the final analysis, the attainment of CBHP's ultimate objective and the immediate need of providing health services to the neglected communities of the rural areas, lie in the effectivity of the CHWs who serve as frontline workers of the program.

In the CBHS program areas, CHWs are chosen by the communities that they will eventually serve. The process begins at the GKK district meeting convened by a parish core group member from the area. Usually done as the last activity of this community orientation seminar held prior to establishing a CBHP in a community, the PCG member explains the roles of the CHW in the program and of the community in choosing and supporting them. Actual selection varies from community to community. In some, CHWs are chosen upon the strong recommendation of the parish priest and, given his clout in most communities, his recommendees are those that the people select; in others, people choose their CHWs by a show of hands.

Interviews with people in two parishes in Kidapawan revealed the criteria for choosing CHWs. One summed them up as follows:

> They are people with a strong commitment to serve. They possess leadership qualities, but those who are already in leadership positions in other programs or organizations are not chosen because they would have less time for health. They must be trustworthy. They must, finally, be able to read and write.

The nominees are trained in groups of seven to fifteen. Parish and diocesan core group members say that seven is the ideal number for a training. Training a group of less than seven is not time efficient, while a group of more than twelve is too large for the training staff to give the trainees the proper individual attention.

The training staff is generally composed of one or two parish core group members, all of whom, in Kidapawan, are former CHWs themselves. They are sometimes assisted by and usually request assistance from the diocesan staff, all of whom are also either former CHWs or have gone through or familiar with the curriculum.

The basic health skills training curriculum used in Kidapawan consists of twenty-one topics, including the orientation to CBHP. If taken intensively, the course takes ten eighteen-hour days to complete. More usually, it is given on a staggered system lasting from eight to twelve months, five days per month or every other month. Both trainees and staff prefer the staggered system for it does not keep them (the trainees) from their families and income-generating activities too long. The staff, on the other hand, are not also "tied to one place too long" and, more importantly, they all agree that the staggered system produce better CHWs of "better quality" since it gives them time to absorb the contents and are not rushed to proceed from one topic to the next. And, since they are allowed to immediately put to practice what they have learned, they are able to discuss their experiences when they again assemble to resume their training the following month.

The CHWs in Kidapawan and other CBHS areas are expected to perform exactly the same functions as those of the RM CHWs. They are expected to share with the people in their communities what they have learned from the training sessions they attended through mass education campaigns and health education classes. They provide health services to the people "twenty-four hours of the day," by diagnosing patients who call on them and preparing and dispensing medicines and giving injections. They coordinate with government personnel for immunizations and TB control and sanitation drives which they themselves are also expected to organize. Cases they can not themselves handle they refer to the RHU, the government or private hospitals and clinics. CHWs

also assist when government health personnel and other agencies hold clinics in their areas and they rotate reporting to the parish for clinic duty.

CHWs in Kidapawan and the other areas also face the same problems as those of the RM CBHDP which lead to the same consequences: "dropping-out, inactivity, lying low." Although the figures for those of Kidapawan are lower than those of the CBHS network as whole, they should still cause some alarm. In 1986-87, for example, of the 681 CHWs who had completed their basic health skills training, 286 or almost 42 percent had either dropped out (144), were inactive (97), or were "lying-low" (45). The figures for 1987-88 do not differ significantly: of the 700 CHWs who had completed the basic health skills training, 241, or almost 35 percent had either dropped out (56), were inactive (122), or were "lying low" (63).

Of the 460 undergoing training in 1986-87, on the other hand, only 208 or 45 percent were actively pursuing the training while 55 percent had either dropped out after a few sessions, were inactive (not consistent with their attendance) or were "lying low" (not practicing what they had learned). For 1987-88, of the 642 who started the training, 377 (less than 59 percent) were actively pursuing it, while 265 had either dropped out, were inactive or "lying low."

For the whole CBHS network, as of December 31, 1988 of the 6,918 CHWs who had completed the basic health skills training module, only 2,309 or less than 34 percent were counted as active while 1,697 (25 percent) were inactive and 2,912 (42 percent) had dropped out. Reasons for dropping out, inactivity or lying low have remained the same through the years. A survey of CHWs conducted by the CBHS Central Office in July 1983 cited nine reasons: 1) marriage; 2) to engage in income-generating activities; 3) schooling; 4) change in occupation; 5) transfer of residence; 6) militarization; 7) health; and 9) death. From interviews with program personnel at all levels and CHWs in Kidapawan at various times this year, two reasons stood out: militarization and the need to earn a living. In an effort to address these two major and other problems of CHWs, attempts were made as early as 1983 to form CHW organizations at the parish level and a federation of these parish CHW organizations at the diocesan level. The diocesan organization is in place with a set of officers, referred to as the Council, consisting of a chairman, secretary, treasurer, and auditor. Only in four parishes, however, had CHW organizations been formed - Magpet, New Rizal, New Cebu, and Doroluman. It is ironic that the reason for the slow pace of organizing CHWs can be traced to what the organization is supposed to address in the first place - militarization. As the diocesan CHW organizer put it, "CHWs are afraid of forming and joining organizations because the military tags grassroots organizations as subversive and would-be members fear the harassment, torture, and even liquidation if they organize or join associations. Their fears seem to be well- founded. A number of CHWs and health workers have already been killed or have disappeared mysteriously in recent years.

Of the four parishes with CHW organizations, only in two (Antipas and New Rizal) have income-generating projects been started for the benefit of CHWs. In both the projects are poultry-raising where the families served by the CHWs contributed a chicken each. The CHWs raised the chickens and the chicks produced are shared with the contributing families. "The returns are not much," admitted a CHW organization officer, "but it is better than nothing."

The diocesan staff is also providing assistance by taking out a loan from the Bishop and used it as capital for a "buy and sell" venture in Chinese liniment (Polar Bear). The P2,000 monthly income from the project is used to defray the traveling expenses of CHWs in attending trainings and meetings and to pay a P300 monthly honorarium to three members of the diocesan CHW council.

The parish also helps with some of the traveling expenses. "But there are many parish programs," complained one parish priest, "and all of them request transportation money. But as parish funds are also limited, not all of their requests can be accommodated."

The community members themselves whom the CHWs "serve do their best to help." However, since the majority are also poor, "all they can help with is to provide food during trainings and meetings."

Those who persevere as CHWs despite the difficulties find it "rewarding. It's fulfilling to serve those who need help," says one CHW in the parish of Tulunan. Being a CHW also provides opportunities for "personal growth, being one among the few avenues open to most to acquire "knowledge and additional skills." Those who excel as CHWs in their GKKs can further hone their skills by training in advanced health skills and such non- health topics as teaching-learning skills and they can be chosen to assume parish level positions such as parish coordinator or core group member where they acquire "more knowledge and other skills" (e.g., management, clerical work). Among them a few can advance to join the staff at the diocese and even in the Central Office. One CHW, however, admitted that "with the skills I have and will continue to acquire as a CHW, I hope to go to Saudi to work there as a domestic helper.,

Networks

A major component of the community-based health approach to health is the development of networks, of forging links and alliances with other organizations, both government and non- government. These relationships are important for they generate moral as well as material and financial support and facilitate the propagation and popularization of the program's philosophy and orientation.

Although there have been individual and informal relations among CBHP staff members and government health personnel and private practitioners living in the same communities, Kidapawan's first attempt to establish a working relationship with a government agency was in 1983 when, through such communal ties, the personnel of the Rural Health Unit in M'lang gained interest in learning more about CBHP by inviting the latter's staff to give a seminar on herbal medicine to the their barangay health workers. It took several years more before government and CBHP collaboration was re-established. In April 1986, the new Minister of Health, Alran Bengzon, convened the First Mindanao- wide Consultation between NGOs and the Ministry of Health in Cagayan de Oro City. In attendance were several program staff members of the CBHS network, including the program coordinator of Kidapawan who says that "the consultation was primarily a getting to know each other session," although general areas where government and NGOs could work together were outlined and in a "closed-door conference with the Minister, there was an honest exchange of ideas between

the government and NGOs and their perceptions of each other. One of the results of the conference was "government's recognition of NGOs as partners in development."

Following the Cagayan de Oro consultation, a smaller meeting was convened in Cotabato city attended by Minister Bengzon and the personnel of the Ministry in Region 12 and the representatives of NGOs operating in the area. The result of this meeting was the formation of the Council for Coordinating Health Concerns composed of representatives of government health agencies and NGOs. With this, a new partnership with the government was forged.

The first collaborative effort between CBHP and government was CBHPs participation in the latter's RHP program involving new medical graduates who volunteer to work in the rural areas for a six-month period. In Kidapawan, two such volunteers were with the program from July to December 1986, among the eleven who were attached to the various program areas of the CBHS network. In assessing the program, staff members agree that the volunteers were helpful particularly in upgrading the skills and expanding services. In other program areas, however, some irritants developed between the RHU personnel and the CBHP who were "accused of grabbing the patients" of the RHU.

Although no other volunteers came to work in Kidapawan under the RHPP, GO-CBHP collaboration in Kidapawan continued. CBHP has referral arrangements with the government hospitals in the province and the provincial integrated health office makes medicines and vaccines available to the program. Both agencies also use each other's resources in upgrading their staffs skills. For example, the staff of the provincial health office conducted a training activity in malaria smearing for CBHP personnel, while the former participated in a recent symposium on rational drug use sponsored by CBHP. Both agencies are also actively collaborating in mass education campaigns, being the lead actors in the provincial Task Force on Pesticides and Drugs.

One of the most impressive activities jointly undertaken by the CBHP and the Provincial Health Office is the outreach program. One recent outreach activity was held in an evacuation center in the municipality of Tulunan where both government and CBHP doctors and other medical personnel treated some 500 patients and performed on-the-spot laboratory examinations.

The staff of another NGO operating in the area, the PRRM, assisted in keeping order and in recording the patients' biographical data. According to the Provincial Governor, who is herself a physician and assisted in the activity, the Province of Cotabato dispensed "at least P30,000 worth of medicines that day." But, she adds, "that's where government money is supposed to go anyway, the people."

The CBHP in Kidapawan has been less successful in establishing links with private medical practitioners and their professional associations. Many have simply not heard of the program or are only vaguely aware of its existence. Others deride its practice of medicine as illegal, claiming that "the practice of medicine requires proper training in recognized institutions." The local chapter of the Philippine Medical Association, on the other hand, has taken a stand opposite that of CBHP. the most recent of which is its opposition to the generics law which CBHP supports. The program coordinator has "given up on establishing any kind of relationship with the PMA."

The program has however been able to establish referral arrangements with a few privately-run medical clinics. This has proven beneficial to the patients as CBHP was able to work out a discount in the fees charged to CBHP-referred patients. The system also ensures "correct diagnosis," although CBHP has relied less now on private and government doctors for this since a physician joined its staff.

Concluding Remarks and Recommendations

After over seven years, CBHS has gone a long way in building up the community-based health program started by the Rural Missionaries in Mindanao in 1975 and in achieving the program's ultimate objective of the promotion of a self-reliant health care system in the context of holistic and integrated development. The organization's achievements are indicated by the quantitative growth of the number of areas where the program is in place and the number of community health workers trained and are actually serving the communities where they reside: from a single diocese in 1975, the program now operates in eleven, covering 911 mostly remote and neglected barangays, with approximately 2,309 active community health workers.

The program has contributed to raising the people's level of awareness of the root causes of health and other societal problems. Through the provision of direct health services, the development and use of appropriate technology, and by serving as entry points in unorganized communities the program has also supported genuine people's organizing efforts and assisted in strengthening their organizations. Moreover, it has encouraged health and other intermediate sectors to share their resources, knowledge and skills in the service of the people. Finally, through the development of local and international linkages, the program has drawn support for the people's desire for social transformation.

Despite these achievements, the review indicates that CBHS should now respond to a number of issues to further ensure the attainment of its goals. These issues primarily concern organizational matters and the task of strengthening the capability of the agency's staff in planning, monitoring, and evaluating, and otherwise managing their health program.

First, as was noted, a reading of CBHS documents reveal conflicting provisions. For example, the number of members in the various organizational units, particularly the Board of Directors, and from which sectors these members are to be drawn have not been specified. The documents reviewed and interviews with program staff also reveal that the functions of the various organizational units have not been clearly distinguished. For example, the tasks assigned to the Program Support Desk do not substantially differ from those of LACEIR's. (The reason why the Program Support Desk was not treated separately in the earlier discussion of the CBHS Desks). On the other hand, there are units included in the organizational chart which do not actually operate, while there are positions, e.g., the Regional Program Coordinator/President, who has been given important functions, that are not included in the organizational chart. CBHS, moreover, continues to create additional organizational units (e.g., the Advisory Council) despite the difficulties it is already

encountering in convening existing units or filling vacancies in them. Relatedly, CBHS's organizational structure contains too many layers or levels, which does not necessarily give the organization a broad decision-making base since members to these various layers/levels are drawn from the same sectors. Finally, the functions of organizational units are confused with those of positions within those organizational units. These findings suggest that a review of the agency's organizational structure may be in order. This review should result in the preparation of a functional chart, which shows the summary of functions per organizational unit, and an organizational structure showing the position titles and the names of incumbents per per organizational unit. Since this review takes into account the needs of the program and the resources available for personnel salaries and benefits, it may entail the phasing out of some positions and the fusion of others. A clearer description of the roles, responsibilities, authority, and accountability of the organizational units, specifying their administrative, coordinative, and functional relationships, and job descriptions and specification of all positions should be prepared. Lastly, CBHS would also benefit from a schedule of approval authority, which specifies which unit or position in the organization has recommendatory or approval authority in so far as specific items or issues or decision-making are involved. In brief, streamlining of the organization is called for through which responsibility, authority, and accountability can be more clearly and easily carried out.

Second, the program's relationship with the Bishops and parish priests must be clarified. This will minimize the occurrence of conflicts such as those experienced with the Bishops of Dipolog and Bukidnon which led to the dissociation of the programs in these dioceses from the church organization. It is even suggested that CBHS and the Bishops sign a memorandum of agreement which spells out their respective roles in the program.

Third, it is also suggested that diocesan programs clarify their organizational relationship with the Church. Although no problems were reported to the investigator, clearly delineating roles and specifying expectations will minimize the occurrence of problems. Currently, although diocesan health programs have their own General Assemblies which are described to be the highest policy- and decision-making body, their policies and decisions are in theory subject to the approval of the Diocesan Pastoral Team. Thus, despite claims to the contrary, Diocesan Programs do not have organizational integrity which is a potential source of conflict given the known political differences between the program and most Church officials.

Fourth, internally, the relationship of the the Diocesan Programs with the CBHS Central Office and the Diocesan Programs with those of the Parish Programs needs to be clarified. Roles and expectations must be clearly spelled out - although it is recognized that these could change and can vary from area to area. Related to this, as local program staff acquire the necessary capabilities in running their own programs, the Central Office should consider what its role in local problems would be. For example, one of the major services offered by the Central Office to the local programs is assistance in the conduct of training in basic and advanced health skills for CHWs. However, many diocesan programs now have sufficient personnel who can conduct their own training activities without assistance from the Central Office. Thus, as the goal of self-reliant local programs is being realized, albeit slowly, the Central Office should start considering new kinds of services it can provide to the local programs. In the process, CBHS may have to redefine its role in the community-based program as a whole. In this regard, it is suggested that CBHS exert efforts

in assisting local programs develop more creative methods to promote primary health care amd preventive medicine. While the organization reports developing modules for training CHWs in advanced health skills, less priority seems to have been given to developing and/or adapting new technologies for health education and preventive medicine.

Fifth, one of the major difficulties encountered in this evaluation was the inadequacy of the progress reports prepared by the organization. Activities reported were consistently similar through the years, even as other program documents claim that thrusts and orientation are redefined in response to changing needs and conditions. Thus, progress reports do not clearly show the program's growth and the extent to which plans for a given period had been realized and are, therefore, not helpful for evaluating performance and in planning directions. It is strongly recommended that the reporting system be improved. Reporting by objective is suggested.

Sixth, the weakness of the reporting system is related to weaknesses in the planning system. Currently, the program undergoes a comprehensive evaluation and holds a planning activity every two years during the so-called Staff Conference. The results of the evaluation are then used as the basis for defining future thrusts and directions. As can be gleaned from earlier sections of this report, CBHS is particularly strong in setting goals and objectives. These goals, however, are phrased in very broad terms as: "consolidation of basic skills and developing of advanced skills; ". . . consolidation and development to higher levels of skills needed to a higher level of health service;" consolidation/systematization and improving the capacities and capabilities of the organizations. . .; and "deepening of our understanding of the philosophy and orientation of the community-based health program." The Conferences do not proceed to operationalize such goals and no indicative plan are prepared. Consequently, measurable targets could not be set resulting, in turn, in weak monitoring and evaluation procedures. Moreover, two months are needed to collect the data for the evaluation during the Staff Conference, which could be considerably reduced if the quarterly reports of the diocesan programs were designed in such a way that it would provide most of the data requirements of the evaluation. Although efforts are being exerted to improve the reporting system, its usefulness could be maximized if it were integrated into an improved planning, programming, recording, monitoring, and evaluation procedures. It is probably about time for CBHS to bring in technical assistance to upgrade its capabilities in these procedures, in the preparation of project proposals of such quality that would increase its chances for approval, and in otherwise running the program.

Seventh, it is also perhaps time that the organization seriously address the problem of high personnel and CHW turnover. A review of the selection process is recommended and new strategies for keeping personnel must be considered. Finally, as one of the major causes of the high turnover rate is financial, immediate solutions to the problem must be looked into.

Eighth, solutions too must be found to ease CBHS's financial difficulties. As it begins to suffer the consequences of its previous heavy reliance and dependence on a single funding agency for much of its financial requirements, it must now consider strategies for broadening its financial support base. Local sources, including government agencies, which have not been tapped extensively, could offer the organization considerable assistance.

CHW SKILLS, KNOWLEDGE, AND ATTITUDE TEST

by

Dr. Jaime Galvez-Tan

I. INTRODUCTION

The evaluation of the knowledge, skills and attitudes of volunteer community health workers of community based health programs in the Philippines has been done in conjunction with the 1989 National Impact Evaluation of Community Based Health Programs. Being part and parcel of the impact evaluation, this followed the over-all framework in the selection of the geographical areas where the community based health programs are located i.e. Isabela and Pampanga for Luzon, Leyte for the Visayas, and Davao del Norte, South and North Cotabato,Bukidnon and Misamis Oriental for Mindanao. These were the programs where there are community health workers who have finished their basic health skills training before the first of January 1986. (For further details, please see the text on the framework for the evaluation of CBHPs in the Philippines).

II. PROCESSES IN THE DEVELOPMENT OF THE EVALUATION TOOL FOR TESTING THE KNOWLEDGE, SKILLS AND ATTITUDES OF COMMUNITY HEALTH WORKERS

The following steps were done in the development of the evaluation tool:

1. Review of the Common Health Problems in the Philippines

The 10 leading causes of mortality and morbidity among infants, children and adults for the past fifteen years (since 1975) were reviewed. The various causes which were persistent over time were noted. These were pneumonia, tuberculosis, diarrheal diseases, malnutrition, measles and accidents. The conclusion was - if these were the major health problems confronting the general population, these would be the major topics that community health workers should know in order to be relevant and of assistance to their communities.

2.Review of the Curricula of Basic Health Skills Utilized by Various CBHPs

This was to find out whether the curricula being utilized by CBHPs contained the topics on the prevention and treatment of the major health problems identified in step one. Indeed, all the topics were included in the curricula and training syllabi.

The printed manuals being utilized by community health workers were also reviewed to find out the content of the above mentioned topics. These manuals were: Our Health Our Lives, AKAP Mini-Manuals and the CPHC Hand-outs.

Particularly noted in the review of training curricula and printed manuals was the importance given to maternal care (pre- natal, natal and post-natal care) and the use of medicinal plants.

III. DETERMINATION OF THE "MUST KNOW" ON THE TRAINING OF COMMUNITY HEALTH WORKERS (CHWs)

After the review of the common health problems and the curricula and training manuals utilized by CBHPs, the evaluation team decided that the CHWs will be tested on the following topics: pneumonia or acute respiratory infections, tuberculosis, malnutrition, measles, diarrheal diseases, care of the pregnant woman and herbal medicine.

As to the attitudes to be tested, the following were found to be the attitudes consistently demanded of community health workers as expressed in the training curricula of CBHPs: compassion, perseverance, camaraderie, medical neutrality, sense of duty, determination, discretion, articulateness, dedication, commitment, when to refer, honesty and humility.

As for the skills, the CHWs were to be tested in health education, in particular, giving advice to a normal pregnant woman; the preparation of home made oral rehydration (sugar/salt) solution; and the preparation of herbal medicines.

In making the questions of the evaluation tool, the evaluation team was guided by the book of Abbatt - "Teaching for Better Learning". Thus, for the knowledge part, a multiple questionaire was prepared; for the skills tests, a checklist of actions needed to be done was prepared; and for the attitudinal portion, a multiple choice questionaire and a Likert scale tests were prepared.

For testing the knowledge and skills of the CHWs, the "must know" were fleshed out of the "useful to know" and "nice to know" content. Only the "must know" were the basis for finalizing the multiple choice questionaire and the check list.

The knowledge tests were further subjected to a critique on whether the questions formulated were asking for a "recall", "application", "analysis" or "integration" of a particular knowledge (must know) on the common health problems. It was decided that in the selection of questions, there should be a balance of questions between mere "recall" of a knowledge and the "application" or "analysis" of a knowledge.

IV. PRE-TEST OF THE INSTRUMENT QUESTIONNAIRE

The questions were originally written in English. (see annex I). These were then translated into Tagalog. The knowledge and attitude portion were pre-tested in two peri-urban communities where community health workers have been active before January 1, 1986. A total of 15 community health workers took the pre-tests.

An open discussion on the questions followed after the CHWs have finished responding to the questionaire. Notes were taken on the time consumed in taking the examinations and what questions were not clear or where they found difficulty in answering.

The community health workers found it very difficult to answer the Likert scale test on attitudes. They found it hard to distinguish what "strongly agree" and "agree" meant or for that matter what "strongly disagree" and "disagree" meant. For them, they say, once you have agreed or disagreed, that was already a decision. This was also the portion which took them a long period of time to answer. The evaluation team decided to totally scrap this portion since there was another measurement for the attitudes, which was in the form of a multiple choice questionaire.

An item analysis on each of the questions was also done to guide the evaluation team on what questions were easily answered and what questions were found too difficult to answer.

V. ACTUAL CONDUCT OF THE EVALUATION TOOL

The English and Tagalog versions of the evaluation tools were further translated into Ilocano, Waray and Cebuano. The translations were done by persons not connected with the CBHPs.

Three teams were formed to conduct the evaluation. Dr. Joseph Carabeo conducted the evaluation in the provinces of Isabela (Ilocano language version) and Leyte (Waray language version). Dr. Ruben Caragay conducted the evaluation in Pampanga using the Tagalog version. Dr. Jean Lindo and Ms. Cecille Payoyo conducted the evaluation in cities of Davao and Cagayan de Oro as centers for the various provinces in Mindanao, using the Cebuano language version. Dr. Jaime Galvez Tan supervised the testing done in Davao City.

All of the evaluations were done in the months of July and August 1989.

VI. LIMITATIONS OF THE EVALUATION

It is recognized that written examinations are not the only way to evaluate the knowledge, skills and attitudes of community health workers. The written examinations should be corroborated with the supervisory reports of the CBHP staff responsible for the community health workers, the feedback from the members of the community being served, peer evaluation as well as self evaluation by the CHWs themselves. All these are very important in getting a fair measure of the competency of community health workers. It is advisable therefore that CBHPs consider all of these when fully evaluating the knowledge, skills and attitudes of community health workers.

Pre-test of the evaluation tool was done only for the Tagalog version. The Ilocano, Waray and Cebuano translations were not pre-tested due to lack of personnel and time. The item analysis done for all the four areas, however, will be compared to determine whether certain questions will have to be deleted to have a uniform rating scale. No pre-test was also done for the skills portion of the evaluation for the same reasons given earlier.

The question items were purely of the multiple choice variety. This was to avoid bias in the conduct of the evaluation, knowing before hand that three teams will conduct it. However, the skills tests, although already formulated with a checklist, could still be subjected to bias, since the questions were read orally (which can give the examiner leeway to add more details to the situation being presented in the questionaire). Another possible source of non-uniformity was that the materials utilized in each of the places where the tests were conducted could facilitate or block correct responses depending on how much available materials the host area was able to produce and also to what extent the host area can replicate or simulate the setting/scenario for the situation demanded by the questionaire. For example, the skills testing for the preparation of home made oral rehydration solution requires a simulation of an ordinary home kitchen setting of a poor rural family, preferably with a pre-school child to demonstrate the method of giving the oral rehydration solution. Only two of the host areas were able to approximate the necessary requirements.

Taking the above mentioned limitations of the evaluation, it can still be said that given the circumstances, what has been done was implemented in the best possible way it can be done. This was also the first time such endeavour with such magnitude was conducted. This evaluation could therefore serve as a benchmark for future evaluations of community health workers in the Philippines.

VII. PROFILE OF THE COMMUNITY HEALTH WORKERS EVALUATED

A total of 82 community health workers (CHWs) were tested. All were randomly selected from the list of CHWs from CBHP areas involved in the impact evaluation.

Geographical Origins

Of the 82 CHWs, thirty four (34) came from Northern Mindanao (Bukidnon, Misamis Oriental, Agusan and Lano del Norte); twenty from Southern Mindanao (Davao del Norte, North and South Cotabato); fourteen from Leyte, six of whom are Tacloban City based; six from Pampanga and eight from Isabela.

Table 1. Geographical Origins of CHWs Tested

Location	Number	Percentage
Northern Mindanao	34	41%
Southern Mindanao	20	24%
Leyte	14	17%
Pampanga	6	8%
Ilagan	8	10%

Occupation

Forty four percent (44%) or 36 CHWs placed their occupation as housewives. Twenty six (26) per cent or 21 CHWs are farmers, thirteen per cent (13%) or 11 CHWs placed their occupation as CHWs. Whether or not they are full time or not was not verified further. The others are workers, students, barber, parish trainor, parish staff, banana vendor and businesswoman.

Table 2. Occupation of CHWs

Occupation	Number	Percentage
Housewives	36	44%
Farmers	21	26%
CHWS	11	13%
Dressmaker	4	5%
Others	10	12%

Sex, Civil Status and Age

Of the 82 CHWs tested, eighty three percent (83%) or 68 are females. Only twelve or fourteen percent (14%) are single.

In terms of age, the range is from 18 years old to 63 years old. The youngest is from Iligan City, female, a high school cgraduate, has worked as a CHW for 2 years having taken the basic health skills training. The eldest is a housekeeper from Tacloban City, finished second year high school and has worked as a CHW for 13 years already. The mode for the age group is the 25-29 years old bracket. The majority (51 CHWs) belong to the age bracket 20-44 years of age.

Table 3. Age Ranges of CHWs Tested

Age Range	Number
15-19	1
20-24	6
25-29	16
30-34	10
35-39	13
40-44	6
45-49	12
50-54	10
55-59	5
60-64	2
N.A.	1

Number of Years of Service as CHWs

Two CHWs, both from Leyte, have served for 13 years. Six CHWs have served for only a year (2 from Isabela and 4 from Mindanao). The mode (14 CHWs) in the number of years of service is three (3) years.

VII. ANALYSIS OF THE RESULTS OF THE CHW SKILLS TEST

A. KNOWLEDGE PORTION

The knowledge portion of the test had 50 items. The range of scores were from 26 to 49. Majority (54% or 39 CHWs) got scores ranging from 41-45.

The CHWs with the highest score comes from Zamboanga del Sur. She is a housekeeper, 36 years old and finished grade school. She has finished both basic and advanced health skills. She has been a CHW for six years. The CHW who got a score of 26 comes from Agusan del Sur. She is 50 years old, finished Grade V and has served as CHW for 7 years.

Table 4. CHW Knowledge Test: Frequency and Percentage of Scores

Range of Scores	No. Of CHWs	Percentage
26-30	1	1%
31-35	10	12%
36-40	18	23%
41-45	39	54%
46-50	14	10 %
	82	100%

In what items did most CHWs commit their mistakes? These would be the areas where their training will need more emphasis, if not altogether a change of approach in teaching-learning such knowledge.

-74% still believe that tuberculosis is inherited;
-68% think that BCG cures tuberculosis;
-51% do not recognize the multi-factorial causes of malnutrition;
-46% do not know the drug of choice for pneumonia;
-43% think that the color and nature of the phlegm isa better differentiating factor than respiratory rate in the diagnosis of pneumonia,
-34% could not distinguish a low grade fever;
-31% do not know the right time to give measles immunization;
-29% still believe that TB patients must be hospitalized;

The CHWs are very strong in the following knowledge:

-home remedy for fever
-transmission and complications of measles
-duration of tuberculosis drug therapy
-home remedy for cough
-community action for malnutrition
-oral rehydration
-need to continue breastfeeding during diarrhea'
-signs and symptoms of dehydration
-treatment of minor wounds; use of tourniquet; need for butterfly bandages;
-predisposing factors in causing pneumonia.

On the whole, knowledge on rational drug use is still weak (e.g. use of penicillin for measles (25%) Decolgen for colds (10%); use of chlorostrep for diarrhea (20%); and treatment for pneumonia (46%). This may be explained that CBHPs have given more emphasis to herbal medicines. The training for rational drug use only started last year, initially for CBHP staff members. Hopefully, knowledge on rational drug use would have reached the CHWs by now.

B. ATTITUDE PORTION

The attitude portion had only 10 items. Generally, almost all the CHWs answered approriately on the what direction to take in certain circumstances, except in the particular instance when asked on the propriety of when a CHW should refer or not refer a patient. Thirty five per cent answered incorrectly on this item.

Attitude being Evaluated	% committing mistakes
1. Compassion, sense of duty	1%
2. perseverance, determination	0%
3. discretion, doctors as co-equal	14%
4. articulateness, friendliness	6%
5. dedication, teamwork, humility, commitment	7%
6. perseverance, dedication, commitment	2%
7. when to refer	35%
8. honesty, humility	2%
9. team work, helpfulness	14%
10. medical neutrality	4%

As earlier stated, values and attitudes are best evaluated in concrete and actuál situations. A written examination should also be accompanied by peer evaluation, self-evaluation and community and staff evaluation of the CHW.

C. SKILLS PORTION

There were three skills tested: demonstration on how to make an oral rehydration fluids using sugar and salt; counselling a normal pregnant woman and demonstration on the preparation of an herbal medicine decoction.

On Making the Sugar-Salt Solution for Oral Rehydration:

There were seven steps that each CHW should be able to demonstrate. They were given a situation in a typical rural home when a pre-school child was having diarrhea. The various necessary materials were all present, the kitchen situation being simulated in the best possible way. Each CHW was tested individually.

In Northern and Southern Mindanao areas, not all who took the written examinations underwent the skills tests. The names of the CHWs were raffled off getting a 60% sample. This was done because of the big number who took the examination taking into consideration the time element in conducting the skills tests.

Herewith are the results:

Steps	% Doing it Correctly
1. Washes hand with soap and water	60%
2. Dries hands with towel	46%
3. Pours boiled water over drinking glass	88%
4. Gets a pinch of salt	63%
5. Gets a teaspoonful of sugar	39%
6. Mixes thoroughly	63%
7. Tastes preparation	35%

In the measurement of the salt, some used the teaspoon to get the salt, using one fourth or one fifth teaspoon. Some used their three fingers in getting the salt. For the sugar portion, most used the tablespoon, with a variety of measurements, usually more than a teaspoonful. Only a third tasted their preparations. The common message in preparing home made sugar-salt solutions is to be sure that the solution is not saltier than one's tears. So it must be tasted, indeed.

This skills test showed where trainors should concentrate their efforts. Also, it would be good to review whether CBHPs have indeed adopted a standard formula for the sugar-salt solution.

The more recent strategy in the prevention/treatment of dehydration due to diarrhea is the use of traditional home fluids like am (rice water). Field workers are highly encouraged to study the home

fluids commonly used in their localities and use these types more than the Oresol or even the sugar-salt solution.

The Southern Mindanao group mentioned in the post-test discussions that some of them have been utilizing coconut water and for this particular group they have never usedthe sugar-salt solution in their practice. These are important considerations to take in the evaluation.

On the Advice to be Given to a Normal Pregnant Woman:

The situation given to the CHW was a pregnant woman, on her fourth month, with her fourth pregnancy came to ask for advice regarding her pregnancy. The CHW was asked to talk as if he/she was giving counsel to his/her fellow community member.

Here are the results:

Advice Given	% of CHWs Giving Advice
1. Breasfeeding	35%
2. Diet and Nutrition	98%
3. Family Planning	33%
4. Personal Hygiene	40%
5. Preparing for delivery	17%
6. Reoular Pre-natal Check-up	80%
7. Tetanus Toxoid Immunization	67%
8. Danger signals of Pregnancy	12%
9. Physical activities/exercise	49%
10. Wamings on drug pharmaceuticals	14%
11. Others: avoid too much sweets, child care and immunization, wear comfortable clothes, rest, don't travel too much.	

The above clearly shows where CBHP trainings have been weak: in the areas of breastfeeding, family planning, preparing for delivery, knowing the danger signals of pregnancy and the rational use of drugs in pregnancy. The household survey of the CBHP impact evaluation has shown that breastfeeding in CBHP areas have been on the decline in an alarming manner (below the national average). It also has shown the desire of mothers to limit their children but since CHWs are not prepared to handle birth spacing counselling adequately, such services are therefore not availed of. CBHPs should seriously consider thess points in revising the curriculum for CHWs. The lack of appreciation for rational drug use is once more reflected in this skills test.

On the Preparation of Herbal Medicine Decoction:

Six steps were identified and each CHW was asked to demonstrate what he/she would do in preparing a cough remedy. All the equipments and herbs were made available, again in a home situation simulated the best possible way.

Steps Taken	% of CHWs Doing the Step
1. Washes hands with soap and water	61%
2. Washes herbs	70%
3. Places 2-3 glasses of water	71%
4. Places three handfuls of chopped herbs	73%
5. Mixes herbs	59%
6. Places cooking pot on top of stove with no cover	67%

This is the portion of the skills test where results were generally satisfactory in all areas. Herbal medicines have been one of the major strengths of CBHPs.

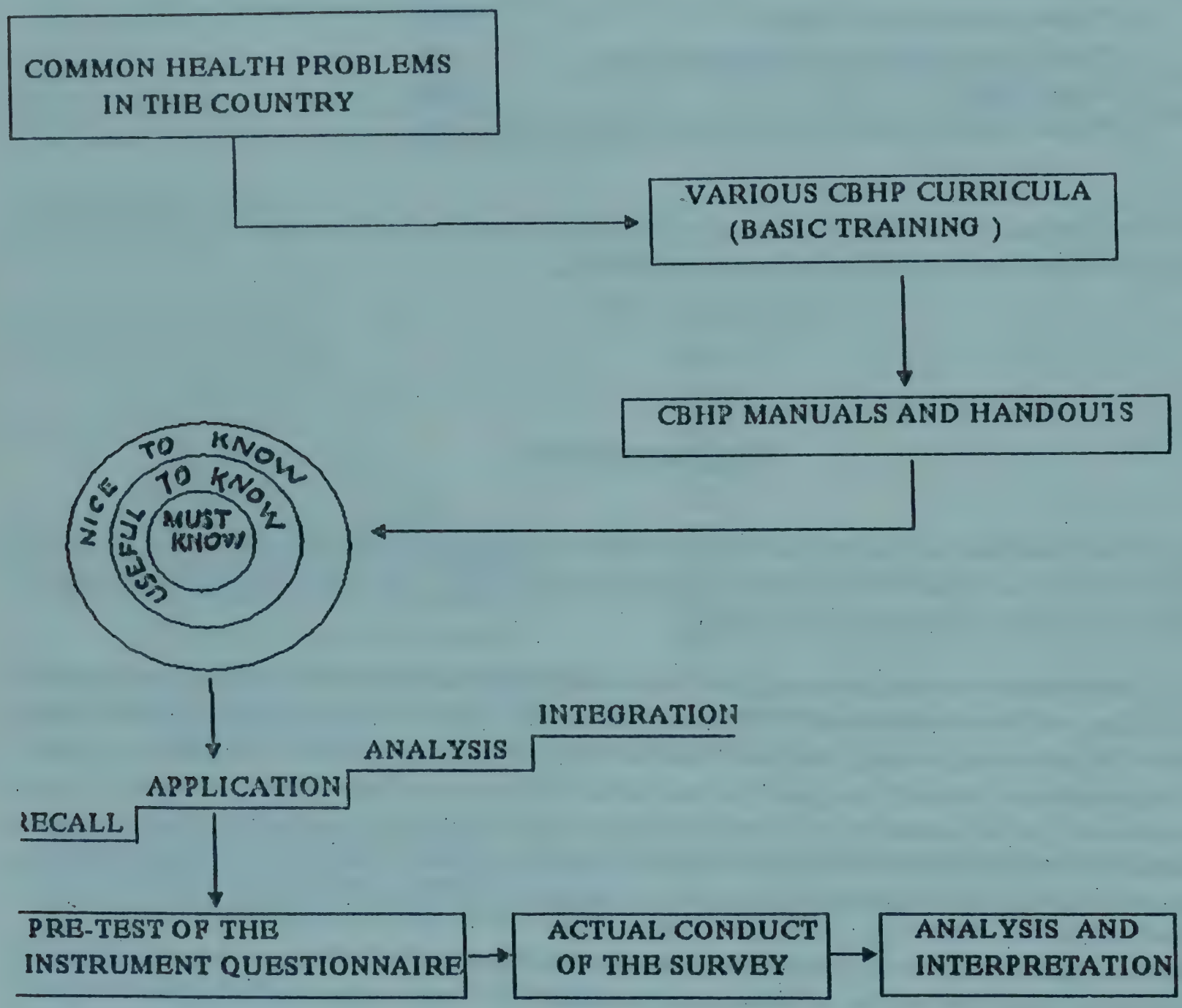
VIII. CONCLUSIONS

Despite the limitations of the evaluation instruments utilized in testing the knowledge, skills and attitudes of CHWs, the results still provide insights on what areas need strengthening, particularly in the training and services components of CBHPs.

Written examinations are not necessarily the best way of judging whether CHWs have indeed acquired the knowledge, skills and attitudes CBHPs want to impart. However, the challenge of developing parameters for evaluating training outcome remains. There are already efforts, in the form of legislations, to legitimize and formally recognize the work done by Community Health Workers in order to give them protection from harassments and provide them avenues for welfare opportunities. Such a situation would definitely create demands on CBHPs to improve their standards of training and therefore the need once more to fine tune our evaluation instruments to measure CHWs skills, knowledge and attitudes.

What this evaluation exercise would like to show is the process of arriving at more appropriate evaluation instruments that would be relevant and attuned to the philosophy and objectives of CBHP. The questionaires (or the tests itself) are mere products of following the process. This is a really a warning not to be fixated on the questionaires, since some groups have already requested to use exactly the same questionaires for their community health programs. As stated earlier, this could be the start for developing such evaluation instruments. Let it also be a regular part of the over-all monitoring and evaluation of health programes. So let the process start!

Appendix 1. Processes In the Development of the Evaluation Tool for Testing CHWs' Knowledge, Skills, and Attitudes



Chapter Five

Summary of Recommendations

Summary of Recommendations

This chapter brings together the major recommendations from the three main components of the study. The recommendations have been grouped into two categories: Program content related and organization-related. Some recommendations are interlinked and should therefore be taken as a whole.

A. ON THE PROGRAM CONTENT

A.1 From the Household Survey

A.1.1 Reassessment of the role of CHWs towards defining their services and functions more realistically and conserving their energies and talents for longer-term service to communities;

A.1.2 CBHPs should review their activities and prioritize the kinds of services they wish to bring to communities;

Prioritize programme goals and services and align these better with implementing strategies and the resources that the programmes have at hand;

A.1 .3 CHWs should make health of mothers and women their special concern;

A.1 .4 CHWs can devote their attention to encouraging mothers to breastfeed, to have their children immunized, bring their babies to health clinics for periodic check-up;

A.1 .5 They can further educate mothers on the nutritional needs of babies and growing children and inform them not only on use of herbal for treating common children's illnesses but on the use of simple and inexpensive treatments like ORT;

A.1 .6 CHWs can also conduct health education sessions on household hygiene and on the value of teaching children clean habits from early on;

A.1 .7 Health education classes can further be supplemented with related reading materials;

A.1.8 CHWs can help identify which crops must be grown in the communities to meet household consumption requirements and improve diets and nutrition of families.

A.2 From the CHW Skills, Knowledge and Attitude Test

A.2.1 Develop parameter for evaluating training outcome.

A.2.2 CBHPs should improve their standards of training CHWs.

A.2.3 Fine tune evaluation instruments to measure CHWs' Skills, Knowledge and Attitude and make them relevant and attuned to the Philosophy and objectives of CBHP.

A.3 From the Case Studies

A.3.1 for CPHC

A.3.1.1 A catalogue of training materials, modules, etc. currently available should be made and sent to CBHPs for easy accessing.

A.3.1.2 A complete directory of all CBHPs in the Philippines should be made containing updated basic information about each of them.

A.3.1.3 Stricter measures in editing, production work and meeting deadlines should be enforced on TAMBALAN and other CBHP publications.

A.3.1.4 Standardized format for the CPHC Progress Report should be developed to facilitate future evaluations.

A.3.1.5 Improve the traditional health care component of CBHPs by developing conveniently located herbal gardens.

A.3.1.6 Intensify local and regional initiatives in research on herbal medicines and home nursing practices.

A.3.1.7 Set up cooperative pharmacies in the communities.

A.3.2 for RM-CBHDP

A.3.2.1 A comprehensive study of CHWs to arrive at a profile of socio-economic background, health skills levels and the number of years they stay with the program;

A.3.2.2 Data recording must be improved and include indicators which should help assess program achievements and/or failures;

A.3.2.3 Reassess the amount of time given to direct organizing work;

A.3.2.4 Document experience in the different areas and popularize them nationwide.

B. ON THE ORGANIZATION

B.1 From the Household Survey

B.1.1 CBHPs should take stock of the number of their programme areas and CHWs and arrive at a more judicious ratio for the area assignment and/or household coverage of CHWs;

B.1.2 CBHPs should cultivate and not only develop working linkages with those groups engaged in delivering Community Organizing, livelihood, skills training and other forms of assistance to communities.

B.1.3 Have a ready directory of nearby or alternative health facilities to which CHWs can refer their cases or clients.

B.1.4 Other health facilities and personnel who are obligated to provide health services must be pressured further to respond to the health needs or demands of households.

B.1.5 Pursue linkages with other government and non-government groups engaged in the larger scale production of herbal medicines to ensure the wider use of herbal.

B.1.6 Linkages with agencies/organizations engaged in assisting rural households with agricultural production should be done.

B.2 From the CHW Skills, Knowledge, Attitude Test

B.2.1 For those in government to legitimize and formally recognize the work done by CHWs to give them protection from harassments.

B.2.2 Provide CHWs with avenues for welfare opportunities.

B.3 From the Case Studies

B.3.1 for CPHC

B.3.1.1 The CBHP Coordinating Body should make regular short, medium and long-term planning targets on the local, provincial, regional and national levels on points such as CBHP expansion areas.

B.3.1.2 For greater efficiency, a clearer delineation between direct and indirect services of the four secretariat can be made.

B.3.1.3 Find some solutions to alleviate the economic aspect of the staff's and CHWs' salaries.

B.3.1.4 GO-NGO cooperation and exchange should be explored and work for the sustenance of such a link by pressuring for a PHC officer/desk/unit within DOH.

B.3.2 for RM-CBHDP

B.3.2.1 Set up a CHW desk to concentrate on CHW training, development and retention needs.

B.3.2.2 More realistic programming should be done in terms of setting-up new health programs or answering requests to assist health programs of other Church groups and need to consolidate existing network of RM.

B.3.2.3 Records and reports should be consolidated and systematized to provide the basis of new plans and the future monitoring and evaluation of the program.

B.3.2.4 Bring in technical assistance to upgrade internal managerial and administrative capacities in running the program.

B.3.3 for CBHS

B.3.3.1 Review of CBHS organizational structure must be done and must lead to the preparation of a functional chart which shows the summary of functions per organiza-

tional unit and an organizational structure showing the position titles and incumbents per organizational unit.

B.3.3.2 Relationship with Bishops and Parish Priests must be clarified.

B.3.3.3 Diocesan Health programs should clarify their relationship with the church.

B.3.3.4 Clarify relationship of Diocesan Health Programs with the CBHS central office and Diocesan Health Programs with those of the Parish Health Programs.

B.3.3.5 Reporting system should be improved with a suggestion that reporting by objective be done.

B.3.3.6 Planning system should be improved.

B.3.3.7 Review staff selection process and new strategies for keeping personnel must be considered.

B.3.3.8 CBHS must broaden its financial support base.